Putnam County Health Department
COVID-19 Vaccine Administration Record

Patient Name _____ **Date of Birth** _____

Address _____ **City** _____ **ST** ____ **ZIP** _____

Phone #_____ **Age** ____ **Sex** □ **Female** □ **Male** **Race** □ **White** □ **Black** □ **Asian** □ **Other** _____

Ethnicity □ **Hispanic/Latino** □ **Not Hispanic/Latino**

Please answer the following questions about the person to receive the vaccine:	**No**	**Yes**
• Am sick today?		
• Ever had a severe allergic reaction to a vaccine or any injection in the past?		
• Have any allergies to polyethylene glycol, polysorbate, potassium chloride, monobasic potassium, phosphate, sodium chloride, dibasic sodium phosphate dihydrate, cholesterol, tromethamine, acetic acid, sodium acetate, sucrose, ethanol, or latex?		
• Am a female between ages 18 and 49 years old		
• Am a male between ages 12 and 29 years old		
• Had COVID-19 and was treated with monoclonal antibodies or convalescent serum		
• Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection		
• Have a weakened immune system (i.e., HIV infection, cancer)		
• Take immunosuppressive drugs or therapies		
• Have a bleeding disorder		
• Take a blood thinner		
• Have a history of heparin-induced thrombocytopenia (HIT)		
• Have received dermal fillers		
• Am currently pregnant or breastfeeding		
Is this your first or second dose of COVID-19? □ First □ Second First dose manufacturer _____ First dose date _____		

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to learn about the benefits and risks (VIS) of the COVID-19 vaccine. Please visit our website (posted at the clinic) to read our Privacy Policy (PP). By signing below, you agree that 1) you reviewed both the VIS and PP, 2) you understand the benefits and risks of the vaccine and you are asking that the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby consent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record and all information on this form to your state's Immunization Program and the CDC, and 5) we can release this record to your doctor, school, or employer if requested. If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient and the patient on this form may receive vaccine with or without you, as the parent or guardian, present at the time of vaccination. After receiving your vaccine we recommend you wait at least 15 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time. Please be aware that staff may be taking pictures for social media and clinic improvement purposes. If you do not want your picture to be taken please let us know at the clinic.

_____ _____

Patient / Parent / or Legal Guardian Signature of Consent **Date**

For office use only

Manufacturer	**Vaccine Lot #**	**Date Administered**	**Admin. Site**	**Dosage**	**Nurse Signature**
				0.3 mL **0.5 mL**	

(Skip this section if we are not billing an insurance plan or if you are providing a copy of your insurance card)

Medicaid Billing ID Number _____

Group Number _____

Name of Medicaid Managed Care Company _____

Medicare Billing ID# _____

Group Number (if any)_____

Name of Medicare Provider/Company _____

Primary Insurance Coverage

Name of Insurance Company _____

Name of person on card _____

Address of Insurance Company_____

ID # on insurance card _____Group # on insurance _____

Birthdate of card holder _____

Address of card holder_____

Secondary Insurance Coverage

Name of Insurance Company _____

Name of person on card _____

Address of Insurance Company_____

ID # on insurance card _____Group # on insurance _____

Birthdate of card holder _____

Address of card holder_____