



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:	Yes	No
• Are you feeling sick today?		
• Ever had a severe allergic reaction to a vaccine or any injection in the past?		
• Have any allergies to Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures; Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids; A previous dose of COVID-19 vaccine; 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 history of myocarditis or pericarditis		
• Have a bleeding disorder		
• Take a blood thinner		
• Have a history of heparin-induced thrombocytopenia (HIT)		
• Have received dermal fillers		
• History of Guillain-Barré Syndrome (GBS)		
• Am currently pregnant or breastfeeding		
Have you ever received a dose of COVID-19 vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No • If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson • Have you received a complete COVID-19 vaccine series (i.e., 1 dose J&J or 2 doses of Pfizer-BioNTech, Moderna)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of last dose _____		

Please visit the CDC website [cdc.gov/coronavirus/2019-ncov/vaccines/index.html](https://www.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 _____