Putnam County Health Department
COVID-19 Vaccine Administration Record

Patient Name _____ Date of Birth _____

Address _____ City _____ ST _____ ZIP _____

Phone #_____ Age _____ Sex □ Female □ Male □ Other

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 an allergic reaction to a vaccine or any injectable therapy 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; or latex?		
• Any problems with previous dose of COVID-19 vaccine?		
• Have a health condition or undergoing treatment that causes moderately to severely immunocompromised? (i.e., cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T cell therapy, hematopoietic cell transplant, or moderate or severe primary immunodeficiency)		
• Had COVID-19 in the past 90 days		
• Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)		
• Have a history of myocarditis or pericarditis		
• History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)		
• Have a history of thrombosis with thrombocytopenia syndrome (TTS)		
• Received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies		
• Vaccinated with monkeypox vaccine in the last 4 weeks?		
• History of Guillain-Barré Syndrome (GBS)		

Have you ever received a dose of COVID-19 vaccine? □Yes □No

• If yes, which vaccine product did you receive?

□ **Pfizer-BioNTech** □ **Moderna** □ **Johnson & Johnson** □ **Novavax** □**Other**_____

• Number of doses of COVID-19 vaccine received? _____**Date of last dose** _____

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.

_____ _____

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

Manufacturer	**Vaccine Lot #**	**Date Administered**	**Admin. Site**	**Dosage**	**Nurse Signature**
				0.25 mL 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_____