COVID-19 Vaccination Form

Jersey County Health Department
1307 State Hwy 109, Jerseyville IL 62052

Patient - Complete all Highlighted Areas

Demographics

Name
Last :_____ First:_____ M.I.:____ Date of Birth: ___/___/___ Age:_____

Address: _____ County: _____ Gender: M F

City: _____ State: _____ Zip: _____ Phone: _____

Parent/ Legal Guardian: _____ Physician: _____

COMPLETE THIS SECTION ONLY IF YOU HAVE INSURANCE COVERAGE

☐ Medicaid: MCO → BCBS IlliniCare Meridian Molina ☐ Title XXI/CHIP
☐ Medicare: Part B Part D #_____ (if part D, need last (4) of SS#) ☐ No Insurance
☐ Private Insurance: Aetna BC/BS Cigna Coventry Health Alliance Healthlink Humana United Health Care

Member ID #: _____ Group #: (if applicable) _____
Policy Holder:_____ ☐ COVID-19 vaccine given at home

Put an "x" in the box below to indicate that you have the HIPAA information.

☐ **HIPAA** – I understand a *Notice of Privacy Practices* is available at my request. Under the Healthcare Insurance Portability and Accountability Act, I authorize to disclose my Immunization Record to my physician and/ or school. I also authorize the following person(s) to have access to my records: (*It's OK if you don't write anyone's name)* _____

Screening Checklist for Contraindications to COVID-19 Vaccine

The following questions help us determine if there is any reason, we should not administer the COVID-19 vaccine today. A "yes" does not mean you can't be vaccinated, but we may need to ask additional questions. Please ask if a question is not clear.

		Yes	No	Don't Know
1.	Are you sick today, or are you currently in isolation or quarantine for COVID19?			
2.	Have you ever received a dose of COVID-19 vaccine? **Date:** **Brand:**			
3.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?			
4.	If yes to question 3, was the severe allergic reaction after receiving COVID-19 vaccine?			
5.	If yes to question 3, was the severe allergic reaction after receiving another vaccine or another injectable medication?			
6.	Do you have a bleeding disorder or are you taking a blood thinner?			
7.	Have you received passive antibody therapy as a treatment for COVID-19?			
8.	Are you pregnant or breastfeeding?			
9.	Have you received a vaccine in the past 14 days?			
10.	Do you plan to receive a vaccine in the next 14 days?			

"I completed this form to the best of my knowledge. I have been given, read and understand the possible side effects that could be caused by the vaccine as described in the Fact Sheet for Recipients and Caregivers EUA of the COVID-19d Vaccine to Prevent Coronavirus Disease 2019 (COVID-19). I give my consent for the vaccine to be given as indicated. I authorize JCHD to release service-related information about me to third-party payors and to bill for services rendered to me. I understand that I will not be billed for the administration fee if I do not have insurance or if my insurance will not pay."

Signature: _____ **Date:** _____
(Patient or parent/ legal guardian must sign)

Vaccine Administered ***Office Use Only***

Vaccine	Date	Manufacturer	Lot Number	Injection Site (Circle)	EUA Fact Sheet Date	Dose Received/ CPT Code (Circle)
COVID-19				LD RD	12/2020	1st Dose 0011A/Z23 2nd Dose 0012A/Z23

Nurse reviewing form and giving vaccine:_____ Date: _____