COVID-19 Vaccine Administration Record

Hancock Public Health will keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that manufactured the vaccine, the vaccine's lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

"I have read/have had read to me the COVID fact sheet. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccines and ask that the vaccine be given to me or the person named below for who I am authorized to make this request."

I acknowledge and understand the intake policy which states that I must have my photo I.D., insurance card and legal documents (if applicable) present at all appointments.

Name: _____ M/F Date of Birth: _____Age: _____Phone_____

Street: _____City: _____ County: _____ Zip: _____

Employer/ Agency: _____

Insurance Information

AS A COURTESY we will bill your primary and secondary insurance carrier if you provide **ALL** the necessary information. **A $25.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS**

PRIMARY INSURANCE

Policyholder_____

Policyholder date of birth_____

Social Security #_____

Relationship to patient_____

SECONDARY INSURANCE

Policyholder_____

Policyholder date of birth_____

Social Security #_____

Relationship to patient_____

Financially Responsible Party

◯ I am responsible for any amount not covered by insurance. Relationship to patient_____

◯ **IF** someone else is responsible for any amount not covered by insurance please list below.

Name: _____ Relationship to patient: _____

Street: _____ Apt: _____ City: _____State: _____ Zip: _____

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I have received and/or read and understand the notice of Privacy Practice regarding the use and disclosure of the health information for me and/or my child. I grant permission for the record to be released to my medical providers, health departments, schools, and day care centers. Int: _____

I grant permission for HPH to release this record to my employer. Int: _____

I authorize my insurance company to assign the amount payable under the client's contract directly to Hancock Public Health. I understand that I am financially responsible for all the charges that are not covered under the insurance plan. I understand that I am financially responsible for any amount due if my deductible is not met as determined by my insurance company. I also understand that I am responsible for notifying the Hancock Public Health if there is a change in the insurance coverage or funding status. Int: _____

Is the person being vaccinated today ever had an anaphylactic reaction (to anything) before: Yes No
(If yes please notify staff immediately and further guidance will be provided). Initial: _____

Is the person being vaccinated today pregnant or breastfeeding? Yes No

If YES- you must consult with your provider prior to being vaccinated. By initialing here I attest that I have consulted with my provider. Initial: _____

I have read/have had read to me and understand this form and have completed it to the best of my knowledge.

Signature: _____ **Date**: _____

HPH Witness: _____ Date: _____

FOR CLINIC/OFFICE USE ONLY

COVID-19 Vaccine Name: _____

Date Administered: _____

COVID-19 Manufacturer: _____

Lot Number: _____

Injection Site: _____

Signature of Administrator: _____

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

immunization action coalition
IAC
immunize.org

Saint Paul, Minnesota · 651-647-9009 · www.immunize.org · www.vaccineinformation.org

www.immunize.org/catg.d/p4065.pdf · Item #P4065 (10/20)