COVID VACCINATION FORM

NAME:_____ DATE OF BIRTH:_____ RACE:_____ SEX:_____

ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____ COUNTY:_____

PHONE #:_____ SOC. SEC#:_____ HISPANIC: ☐ YES ☐ NO

☐ INSURED ☐ NONINSURED

MEDICARE #:_____ MEDICAID #:_____

PRIMARY INSURANCE_____

POLICY Number_____GROUP #_____

NAME OF CARD HOLDER IF NOT SAME AS PATIENT_____

DOB OF CARD HOLDER _____RELATIONSHIP TO PATIENT_____

Email / Preferred Communication Channel:_____

DISCLOSURE STATEMENT: Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include: shortness of breath, hoarseness or wheezing, hives, paleness, weakness, elevated heartrate, or severe dizziness. These symptoms may occur within a few minutes, or up to 48 hours after the vaccination. If you are experiencing any of these symptoms, you should contact a healthcare provider immediately.

VERBAL VACCINATION CONSENT: ☐Yes ☐No

- COVID INFORMATION/VIS provided to recipient of vaccine.
- STATEMENT OF UNDERSTANDING: I understand the information provided to me about receiving COVID Vaccine and I have had the opportunity to ask questions.
- VERBAL CONSENT: The patient or legal guardian has been provided the benefits and potential adverse reactions, and provides consent to receive the vaccine.
- I give my voluntary verbal consent for Albemarle Regional Health Services and/or non-ARHS facility site to use and disclose health/medical information for purposes of treatment, payment, and health care operations. I request that payment of benefits be made to Albemarle Regional Health Services and/or non-ARHS facility site.

Staff Signature Acknowledging Verbal Consent:_____ Date:_____

☐**Under 18 years old: Written parental consent required.** Signature:_____ Date:_____

HEALTH CONCERNS: Are you feeling sick today? ☐No Previously received passive antibody therapy **>** 90 days? ☐

☐ Verbal attestation that you have an immunocompromising condition. **ALLERGIES:**_____

PROVIDERS USE ONLY:

Previous vaccinations: **Dose 1** Date_____ Vaccine name _____ **Dose 3** Date _____ Vaccine Name _____

Dose 2 Date_____ Vaccine name _____

Vaccine given today: ☐Dose 1 ☐Dose 2 ☐Dose 3 Vaccine Mfgr_____ ☐ R Deltoid IM ☐ L Deltoid IM

☐Booster Lot #_____ Admin by:_____

Exp Date_____ Today's Date:_____Time:_____

IMMEDIATE ADVERSE REACTION(s): ☐ Redness ☐ Swelling ☐ Mild Fever ☐ Other:_____

☑	VACCINE TRADE NAME	DOSE	CPT CODE / ADMIN CODE	NDC #
☐	Pfizer – COVID19 Vaccine **1st** dose	30 mcg / 0.3 mL IM	91300 0001A	59267-1000-01
☐	Pfizer – COVID19 Vaccine **2nd** dose	30 mcg / 0.3 mL IM	91300 0002A	59267-1000-01
☐	Pfizer – COVID19 Vaccine **3rd** dose	30 mcg / 0.3 mL IM	91300 0003A	59267-1000-01
☐	Pfizer-COVID19 **Booster**	30 mcg / 0.3 mL IM	91300 0004A	59676-0580-15
☐	Pfizer PEDS 5-11 **1st** dose	10 mcg / 0.2 mL IM	91307 0071A	59267-1055-04
☐	Pfizer PEDS 5-11 **2nd** dose	10 mcg / 0.2 mL IM	91307 0072A	59267-1055-04
☐	Moderna– COVID19 Vaccine **1st** dose	100 mcg / 0.5 mL IM	91301 0011A	80777-0273-10
☐	Moderna– COVID19 Vaccine **2nd** dose	100 mcg / 0.5 mL IM	91301 0012A	80777-0273-10
☐	Moderna– COVID19 Vaccine **3rd** dose	100 mcg / 0.5 mL IM	91301 0013A	80777-0273-10
☐	Moderna COVID19 **Booster**	100 mcg/0.25 mL IM	91306 0064A	59676-0580-15
☐	Janssen	0.5 mL IM	91303 0031A	59676-0580-15
☐	Janssen **Booster**	0.5 mL IM	91303 0034A	59676-0580-15