Todays Date

GENESEE COUNTY HEALTH DEPARTMENT IMMUNIZATIONS

Please Print

Patient's Last Name	Patient's First Name	Middle Initial	Insurance ID #

Patient's Birthdate

Gender ☐F ☐M

Address

City | State MI | Zip

Home Phone | Cell Phone

Email Address

I hereby authorize my insurance benefits to be paid to the Genesee County Health Department (GCHD). I authorize the release of pertinent medical information to the insurance carrier.

Signature of client or parent/guardian

I acknowledge receiving a current Notice of Information Privacy Practices on the above date from the Genesee County Health Department (GCHD). I understand that the Notice contains my rights and GCHD's responsbilities with regards to my protected health information.

Signature of client or parent/guardian

Printed Name of Signer

Race ☐Asian ☐American Indian ☐Black/African American ☐Caucasian or White

☐Hispanic ☐Native Hawaiian or Pacific Islander ☐Other Race ☐Refuse to report

YOU MUST COMPLETE THE PREVACCINATION CHECKLIST FOR THE COVID-19 VACCINE ON THE BACK SIDE OF THIS FORM

Vaccine	Site	Lot #	Dose	CPT	Admin	Admin Fee	Total
			1st	91301	0011A	$23.00	$23.00
Moderna			2nd	91301	0012A	$23.00	$23.00

Vaccine	Site	Lot #	Dose	CPT	Admin	Admin Fee	Total
			1st	91300	0001A	$23.00	$23.00
Pfizer			2nd	91300	0002A	$23.00	$23.00

RN: _____

Allergies: _____

_____

_____

Comments _____

_____

_____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.
If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.
If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
• Polysorbate	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐	☐
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐	☐

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists