

Today's Date

GENESEE COUNTY HEALTH DEPARTMENT IMMUNIZATIONS

Please Print

Patient's Last Name		Patient's First Name		Middle Initial	Insurance ID #
Patient's Birthdate		Gender <input type="checkbox"/> F <input type="checkbox"/> M		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.	
Address				Signature of client or parent/guardian	
City	State MI	Zip		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 responsibilities with regards to my protected health information.	
Home Phone	Cell Phone		Signature of client or parent/guardian		
Email Address				Printed Name of Signer	
Race <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian or White					
<input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Refuse to report					

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

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

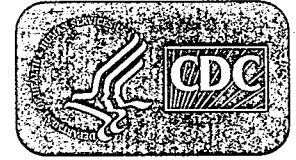
<u>Vaccine</u>	<u>Site</u>	<u>Lot #</u>	<u>Dose</u>	<u>CPT</u>	<u>Admin</u>	<u>Admin Fee</u>	<u>Total</u>
Pfizer			1st	91300	0001A	\$23.00	\$23.00
			2nd	91300	0002A	\$23.00	\$23.00

RN: _____

Allergies: _____

Comments _____

Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

Patient Name _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

Age _____

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

	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? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> 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 _____