Health Department

COVID-19/FLU VACCINE ADMINISTRATION RECORD

Office Use Only:
Date: **Time:** **EMR#:**

SECTION 1: PERSON TO BE VACCINATED INFORMATION *(Please PRINT clearly)*

Legal Last Name:		**Legal First Name:**		**Middle Name:**	
Other Names Used Since Birth:					
Street Address:		**City:**		**State:**	**Zip Code:**
Date of Birth: *mm/dd/yy*		**Phone #**	☐ Cell ☐ Home (Landline)	**Gender :**	☐ Male ☐ Female

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Native Alaskan/American Indian ☐ Multi-Racial (Select all that apply)

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

PARENT/RESPONSIBLE PARTY/LEGAL GUARDIAN

Last Name:		**First Name:**		**Relationship:**	☐ Parent ☐ Legal Guardian ☐ Self ☐ Power of Attorney

SECTION 2: INSURANCE

Which of the following best describes your insurance coverage?

☐ Blue Cross Blue Shield
☐ Blue Care Network
☐ Health Alliance Plan (HAP)
☐ McLaren Health Advantage
☐ Priority Health
☐ Total Health Care
☐ Tricare
☐ Medicaid
☐ Medicare
☐ I do not have Insurance
☐ Insurance Not Listed
*If insurance not listed, does it cover the cost of vaccines?
☐ Yes
☐ No

Enter Insurance Information: ***Only complete if your insurance is listed above***

Primary Subscriber Name:	☐ Self ☐ Parent	**Primary Subscriber Birthdate:** *mm/dd/yy*	
Policy/Contract Number:		**Group Number:**	

SECTION 3: MEDICAL SCREENING QUESTIONNAIRE

1. Is the person to be vaccinated ill or running a fever?	☐ Yes ☐ No
2. Has the person to be vaccinated received any vaccines within the past 30 days?	☐ Yes ☐ No
3. Has the person to be vaccinated ever had a severe allergic reaction to any of the following? • A previous dose of COVID-19 vaccine or any other vaccine? • Medication or therapy, polyethylene glycol (PEG) or polysorbate? • Food item, pet, insect, latex, environmental substance or any other substance?	☐ Yes ☐ No
4. Does the person to be vaccinated have a long-term health condition such as heart disease, lung disease (including asthma), kidney disease, metabolic disease, low platelet count, or a bleeding disorder?	☐ Yes ☐ No
5. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐ Yes ☐ No
6. Does the person to be vaccinated have a health condition or undergo treatment that makes them moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids.*	☐ Yes ☐ No
7. Has the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐ Yes ☐ No
8. Does the person to be vaccinated have a history of myocarditis, pericarditis, or Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?	☐ Yes ☐ No
9. Is the person to be vaccinated currently taking aspirin?	☐ Yes ☐ No
10. Is the person to be vaccinated currently pregnant or breastfeeding?	☐ Yes ☐ No
11. Has the person to be vaccinated received a flu antiviral medication in the past 2-17 days?	☐ Yes ☐ No

SECTION 4: STATEMENT NOTICES & CONSENTS

A	**IN REGARDS TO COMMERCIAL INSURANCES ACCEPTED BY MACOMB COUNTY HEALTH DEPARTMENT:** I authorize any holder of medical information about my child/me to release to commercial insurance or their intermediaries or carriers, information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment below.
B	**NOTICE OF PRIVACY PRACTICES:** I have received a copy of Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

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C	**CONSENT FOR SERVICE:** I have read or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed and to other public health authorities (e.g., for entry into an immunization registry for influenza reporting requirements).

By signing below, I hereby acknowledge that I have read and fully understand the applicable statements on this form.

SIGNATURE of Client/Parent/Legal Guardian		**Date**	
PRINT NAME of Client/Parent/Legal Guardian			

----------Office Use Only----------

Service Location	**Verified Method of Payment**			
	Insurance	**VFC**	**Self-Pay**	**Fee Waiver**
☐ 91 – MC Outreach ☐ 92 – SW Outreach ☐ 93 – SE Outreach ☐ 01 - MC ☐ 02 - SW ☐ 03 - SE ☐ Other_____	☐ Medicaid ☐ Medicare ☐ BCBS ☐ BCN ☐ HAP ☐ McLaren ☐ Priority Health ☐ Total Health Care ☐ Tricare	☐ No Insurance (VFC) ☐ Unlisted insurance that does not cover vaccines (VFC) *Insurance Name (if available):* _____	☐ Unlisted insurance that covers vaccines - (Self Pay) *Insurance Name (if available):* ☐ Cash ☐ Check ☐ Credit Card	☐ Fee Waived No Pay - Code 250

Vaccine Documentation

Nurse Staff ID:		**Nurse Confirmation of Birthdate:** *MM/DD/YYYY*	

Vaccine	**CP/State**	**Manufacturer/Lot#**	**Route**	**Site**	**EUA/VIS Date**	**EUA/VIS Given**
CPT *Covid Pfizer 6m-4y*	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD		☐
CPC *Covid Pfizer 5y-11y*	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD		☐
CPA *Covid Pfizer 12y+*	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD		☐
CMK *Covid Moderna 6m-11y 25mcg/.25ml*	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD		☐
CMA *Covid Moderna 12y+*	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD		☐
CNX *Novavax 12y+*	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD		☐
OTHER _____	☐ CP ☐ State					☐
FLVQ (IIV4)	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD	8/6/2021	☐
FLHQ (IIV4) *65 Years +*	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD	8/6/2021	☐
FLCX (ccIIV4) *2 Years +*	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD	8/6/2021	☐
FLBQ (RIV4) *18 Years +*	☐ CP ☐ State		IM	☐ RT ☐ RD ☐ LT ☐ LD	8/6/2021	☐
FLMQ (LAIV4) 2 yrs thru 49 yrs	☐ CP ☐ State		IN (IntraNasal)	☐ IN	8/6/2021	☐

NEXT DATE DUE FOR IMMUNIZATIONS *(if applicable):* _____

PROGRESS NOTES