Recipient Registration and COVID-19 Vaccine Administration Form

Recipient Full Name: ______________________________ **Date of Birth** ____/____/____
Recipient Email Address: ______________________________ ☐ No email
Have you already registered in the CVMS Recipient Portal? ☐ Yes ☐ No SSN: ____________
Home Phone Number: ____________ **Mobile Phone Number:** ____________
Address: ______________________________ **City:** ____________
Zip Code: ____________ **County:** ____________ **State:** ____________
What is the name of the organization you work for (or reside in)? ____________ ☐ Not employed
If employed, in what industry do you work? (healthcare, food and agriculture, manufacturing, education, etc.)
____

Best way to contact you: ☐ SMS/Text Message ☐ Email ☐ Both ☐ None

Recipient Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Recipient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Recipient Gender: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify

Do you identify as any of the following?

☐ Frontline essential worker (in person at work)
☐ Other essential worker (non-frontline)
☐ Patient-facing healthcare worker or long-term care facility worker
☐ School and child care frontline essential worker
☐ Resident of a congregate/group setting
☐ Resident of a long-term care facility
☐ Student
☐ None of the above

How many conditions do you have that put you at risk for developing severe illness from COVID-19?
☐ None ☐ 1 ☐ 2 or more

☐ **I certify that I am**: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an 'applicable Provider'), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

Recipient signature ______________________________

OFFICE USE ONLY

☐ **Verbal Consent for COVID-19 Vaccine Obtained**
Site of Injection: ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐Other____________
Dose: ☐ First Dose ☐ Second Dose
Administration Date: ____/____/____
Administration Time: ____________
COVID-19 Vaccine Manufacturer: ____________
Lot #: ____________ **Exp:** ____/____/____

Manufacturer sticker (optional)

Vaccine administered by (Clinician Name)____________ **Signature**____________
Vaccinating Clinic Name______________________________

Form Version 8 – 2/11/2021 – North Carolina COVID-19 Vaccine Management System

THE VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL.

If you have your insurance card with you today or if you are not insured, you do not need to fill out the insurance information.

INSURANCE INFORMATION/AUTHORIZATION TO BILL (copy of front and back of insurance card preferred for verification)

Insurance Name: ______________________ Member ID: ______________________

Group Number: ______________________ Phone Number: ______________________

Medical Claims Address: ____

Subscriber Name: ______________________ Subscriber Date of Birth: ____/____/______

Subscriber Address: ____

☐ I authorize payment from 3rd Party Payer (Insurance) and Medicare/Medicaid be made on my behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature above will serve as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to the licensed healthcare provider administering the vaccine for services rendered.

OFFICE USE ONLY (VACCINE BILLING INFORMATION)

1st Dose ☐	**91301-SL** (Moderna SARS-CoV-2 Preservative free vaccine) **0011A** (Administration of 1st dose of Moderna Vaccine) Dx z23	1st Dose ☐	**91300-SL** (Pfizer SARS-CoV-2 Preservative free vaccine) **0001A** (Administration of 1st dose of Pfizer Vaccine) Dx z23	1st Dose ☐	*For future use*
2nd Dose ☐	**91301-SL** (Moderna SARS-CoV-2 Preservative free vaccine) **0012A** (Administration of 2nd dose of Moderna Vaccine) Dx z23	2nd Dose ☐	**91300-SL** (Pfizer SARS-CoV-2 Preservative free vaccine) **0002A** (Administration of 2nd dose of Pfizer Vaccine) Dx z23		

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? (No vaccine if Temp 100.4 or higher, shortness of breath,difficulty breathing, chest pain or sudden onset of confusion)			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? (ONLY able to give same product- CANNOT mix) ☐ 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 (If Yes, NO 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.) (OK to give vaccine, monitor for 30 minutes)			
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? (if yes, defer vaccine for 90 days)			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? no vaccine with a current COVID infection, must recover and complete isolation first.			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? (If yes, defer vaccine for 90 days)			
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? yes, can get vaccine but may have a decreased immune response)			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding? (If pregnant, no vaccine with OB or PCP documentation stating ok to give. If breastfeeding, ok to give after advising there is no info on the safety for child.)			

Form reviewed by ______________________ **Date** ______________