Grand Traverse County Health Department
COVID-19 VACCINE ADMINISTRATION RECORD

NAME (First) (Middle) (Last)			(Maiden) if applicable
ADDRESS (No. & Street) (City)			(State) (Zip)
COUNTY	TELEPHONE		Preferred Method of contact □ Phone □ Mail
DATE OF BIRTH	SEX □ Male □ Female	ETHNICITY □ Arab/Chaldean □ Hispanic/Latino □ Neither	LANGUAGE: □ English □ Other ________________
RACE: (Please check one or more) □ Asian □ Black/African American □ Am Indian/Alaskan □Native □Hawaiian/Polynesian □ Unknown □ White □ Multicultural -SELECT TWO ABOVE		ALLERGIES: □ NONE □ If yes, please list: ________________________________	

FOR VACCINE ADMINISTRATOR USE ONLY:

Dose: Circle One: 1st Dose 2nd Dose 3rd Dose Booster

Vaccine MFG/PRD Name:	Circle One:	Pfizer 5-11	Pfizer 12+	Moderna	Johnson & Johnson
Lot #					
Expiration Date:					
Site:	Circle One:	Left Arm	Right Arm	Left Leg	Right Leg
EUA Fact Sheet Date:					

I certify I have:

- Given a copy of the Emergency Use Authorization Covid-19 Fact Sheet for the vaccination administered today to the client or client's guardian.
- Reviewed the allergies and screening checklist of the client receiving the Covid-19 vaccination.
- Reviewed that the client should wait 15-30 minutes after receiving the vaccine in case of allergic reaction and leaving before that time is against medical advice. Reviewed that if the client suspects an allergic reaction at a later time they should call 911 or go to the nearest hospital.
- Counseled the client/guardian that the person receiving the vaccine today should follow the CDC schedule for vaccination.
- Discussed and given a vaccine record card to the client/ guardian.
- Reviewed information on calling the Grand Traverse County Health Department or their healthcare provider to report a concerning side effect or one that does not go away, how to self-report a reaction to the vaccine through VAERS or the vaccine manufacturers website, and gave the client information on enrolling in the V Safe Text based System for the Public.

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Signature of Vaccine Administrator and credentials *Date*

Grand Traverse County Health Department
COVID-19 VACCINE BILLING FORM

PATIENT NAME

INSURANCE CARRIER (**IF you have Medicare Advantage, please list the Advantage Plan name)**

SUBSCRIBER NAME

SUBSCRIBER RELATIONSHIP TO PATIENT ☐Self ☐Parent ☐Partner	SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SEX ☐ Male ☐ Female
INSURANCE POLICY NUMBER	INSURANCE GROUP NUMBER (if applicable)	

MEDICARE CLIENTS WITHOUT ADVANTAGE PLAN (**Red, White, & Blue Card Number or Social Security Number)**

I authorize the Grand Traverse County Health Department to release my or the patient's medical information to the insurance company listed above for the purpose of billing insurance for insurance payments. I have been offered a copy of the GTCHD Notice of Privacy Practices.

Signature of Patient (or Parent, Guardian, orAuthorized Representative) Date

If you are signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Name of Parent, Guardian, or AuthorizedRepresentative (Print) Phone Number Relationship

Covid-19 Vaccine Minor Consent

- I have received and read the **Pfizer Vaccine Emergency Use Authorization Fact Sheet**.
- I have reviewed, completed, and signed this **Vaccine Administration Registration Form**.
- I have reviewed and completed the **Prevaccination Checklist for COVID-19 Vaccines** for my child.
- I have reviewed the information on the **V-Safe Program** and **What to Expect After Getting a Covid-19 Vaccine**.

By signing below, I acknowledge that I have received, read, and completed all of the forms/documents listed above.
and
By signing below, I authorize Grand Traverse County Health Department to administer the Pfizer vaccine in accordance to the EUA to the above named child.

Parent/Guardian Printed Name: ________________________________
Phone Number: _____________________________
Parent/Guardian Signature: ________________________________
Date: ______________________
Emergency Contact Information (Must be available while minor is at the vaccine clinic):
Name: _________________________________
Phone Number: _________________________