

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 <input type="checkbox"/> Phone <input type="checkbox"/> Mail
DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	ETHNICITY <input type="checkbox"/> Arab/Chaldean <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Neither
RACE: (Please check one or more) <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> AmIndian/Alaskan <input type="checkbox"/> Native <input type="checkbox"/> Hawaiian/Polynesian <input type="checkbox"/> Unknown <input type="checkbox"/> White <input type="checkbox"/> Multicultural -SELECT TWO ABOVE		LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Other _____
		ALLERGIES: <input type="checkbox"/> NONE <input type="checkbox"/> If yes, please list: _____

FOR VACCINE ADMINISTRATOR USE ONLY:

Select Brand	Select Dose
<input type="checkbox"/> Pfizer Maroon Cap 3 MCG/.2mL <input type="checkbox"/> Pfizer Orange Cap 10MCG/.2mL <input type="checkbox"/> Pfizer Gray Cap 30MCG/.3mL <input type="checkbox"/> Moderna Red Cap 50MCG/.25mL <input type="checkbox"/> Moderna Red Cap 100MCG/.50mL <input type="checkbox"/> Moderna Blue Cap - Magenta Label 50MCG/.5mL <input type="checkbox"/> Moderna Blue Cap - Magenta Label 25MCG/.25mL <input type="checkbox"/> Moderna Blue Cap - Purple Label 50MCG/.5mL	<input type="checkbox"/> 1st Dose <input type="checkbox"/> 2nd Dose <input type="checkbox"/> 3rd Dose (Primary) <input type="checkbox"/> 3rd Dose (Immunocompromised) <input type="checkbox"/> 1st Booster <input type="checkbox"/> 2nd Booster

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.

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, or Authorized 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 Authorized Representative (Print)

Phone Number

Relationship

Covid-19 Vaccine Minor Consent

- I have received and read the **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 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: _____