



COVID-19/FLU VACCINE ADMINISTRATION RECORD

	<i>Office Use Only:</i>	
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: <i>mm/dd/yy</i>	Phone #	<input type="checkbox"/> Cell <input type="checkbox"/> Home (Landline) Gender : <input type="checkbox"/> Male <input type="checkbox"/> Female
Race:	<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Native Alaskan/American Indian <input type="checkbox"/> Multi-Racial (Select all that apply)
		Ethnicity: <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino

PARENT/RESPONSIBLE PARTY/LEGAL GUARDIAN

Last Name:	First Name:	Relationship:
		<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Self <input type="checkbox"/> Power of Attorney

SECTION 2: INSURANCE

Which of the following best describes your insurance coverage?	<input type="checkbox"/> Blue Cross Blue Shield	<input type="checkbox"/> Medicaid	<input type="checkbox"/> I do not have Insurance
	<input type="checkbox"/> Blue Care Network	<input type="checkbox"/> Medicaid Health Plan	<input type="checkbox"/> Insurance Not Listed
	<input type="checkbox"/> Health Alliance Plan (HAP)		*If insurance not listed, does it cover the cost of vaccines? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> McLaren Health Advantage		
	<input type="checkbox"/> Priority Health		
	<input type="checkbox"/> Total Health Care		
	<input type="checkbox"/> Tricare		
Enter Insurance Information: <i>Only complete if your insurance is listed above</i>	Primary Subscriber Name:	<input type="checkbox"/> Self <input type="checkbox"/> Parent	Primary Subscriber Birthdate: <i>mm/dd/yy</i>
	Policy/Contract Number:		Group Number:

SECTION 3: MEDICAL SCREENING QUESTIONNAIRE

1. Is the person to be vaccinated ill or running a fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the person to be vaccinated received any vaccines within the past 30 days?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does the person to be vaccinated have a health condition or undergo treatment that makes them moderately or severely immunocompromised? <i>This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Does the person to be vaccinated have a history of myocarditis, pericarditis, or Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Is the person to be vaccinated currently taking aspirin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is the person to be vaccinated currently pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has the person to be vaccinated received a flu antiviral medication in the past 2-17 days?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

COVID-19/FLU VACCINE ADMINISTRATION RECORD

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
<input type="checkbox"/> 91 – MC Outreach <input type="checkbox"/> 92 – SW Outreach <input type="checkbox"/> 93 – SE Outreach <input type="checkbox"/> 01 - MC <input type="checkbox"/> 02 - SW <input type="checkbox"/> 03 - SE <input type="checkbox"/> Other _____	<input type="checkbox"/> Medicaid <input type="checkbox"/> BCBS <input type="checkbox"/> BCN <input type="checkbox"/> HAP <input type="checkbox"/> McLaren <input type="checkbox"/> Priority Health <input type="checkbox"/> Total Health Care <input type="checkbox"/> Tricare	<input type="checkbox"/> No Insurance (VFC) <input type="checkbox"/> Unlisted insurance that <u>does not cover</u> vaccines (VFC) Insurance Name (if available): _____	<input type="checkbox"/> Unlisted insurance that <u>covers</u> vaccines - (Self Pay) Insurance Name (if available): <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card	<input type="checkbox"/> 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
CPBT <i>Pfizer bival 6m-4y</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD <input type="checkbox"/> LT <input type="checkbox"/> LD		<input type="checkbox"/>
CPBC <i>Pfizer bival 5y-11y</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD <input type="checkbox"/> LT <input type="checkbox"/> LD		<input type="checkbox"/>
CPBA <i>Pfizer bival 12y+</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD <input type="checkbox"/> LT <input type="checkbox"/> LD		<input type="checkbox"/>
CMBT <i>Mod bival 6m-5y 10mcg/.2ml</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD <input type="checkbox"/> LT <input type="checkbox"/> LD		<input type="checkbox"/>
CMBK <i>Mod bival 6m-11y 25mcg/.25ml</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD LT <input type="checkbox"/> LD		<input type="checkbox"/>
CMBA <i>Mod bival 12y+</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD LT <input type="checkbox"/> LD		<input type="checkbox"/>
CNVX <i>Novavax 12y+</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD LT <input type="checkbox"/> LD		<input type="checkbox"/>
OTHER _____	<input type="checkbox"/> CP <input type="checkbox"/> State					<input type="checkbox"/>
FLVQ (IIV4)	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD LT <input type="checkbox"/> LD	8/6/2021	<input type="checkbox"/>
FLHQ (IIV4) <i>65 Years +</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD LT <input type="checkbox"/> LD	8/6/2021	<input type="checkbox"/>
FLCX (cclIV4) <i>2 Years +</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD LT <input type="checkbox"/> LD	8/6/2021	<input type="checkbox"/>
FLBQ (RIV4) <i>18 Years +</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IM	<input type="checkbox"/> RT <input type="checkbox"/> RD <input type="checkbox"/> LT <input type="checkbox"/> LD	8/6/2021	<input type="checkbox"/>
FLMQ (LAIV4) <i>2 yrs thru 49 yrs</i>	<input type="checkbox"/> CP <input type="checkbox"/> State		IN (IntraNasal)	<input type="checkbox"/> IN	8/6/2021	<input type="checkbox"/>

NEXT DATE DUE FOR IMMUNIZATIONS (if applicable): _____

PROGRESS NOTES
