Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. **If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given.** It just means additional questions may be asked. If a question is not clear, please as the healthcare provider to explain it.

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product was administered? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax _____			
• How many doses of COVID-19 vaccine were administered? _____			
• Did you bring the vaccination record card or other documentation?	☐	☐	
4. Is the person to be vaccinated have a health condition or undergoing 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, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Has the person to be vaccinated 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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated 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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to the person to be vaccinated:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?

Form reviewed by _____ **Date** _____

JOHNSTON COUNTY PUBLIC HEALTH DEPARTMENT

PATIENT REGISTRATION FORM FOR COVID 19 VACCINE CLINICS

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTH DATE	AGE

MAILING ADDRESS	EMAIL ADDRESS		
CITY	**STATE**	**ZIP**	**COUNTY**

HOME PHONE	CELL PHONE	Social Security Number (Optional)

Marital Status M / S / W / P / D Sex M / F Language: ❑ English ❑ Spanish ❑ Other

Race: ❑ Asian ❑ Black ❑ American Indian /Alaskan Native ❑ White ❑ Hawaiian/Pacific Islander ❑ Other

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Other

TYPE OF VACCINE REQUESTED

☐ Pfizer

☐ Moderna

☐ J & J

Date of Last Vaccine _____

PAYOR :

☐ MEDICARE PART B _____

☐ MEDICAID # _____

☐ INSURANCE NAME & POLICY # _____

_____

☐ SELF PAY $_____

(NPI 1528157211) Insurance Purposes

VACCINE REQUESTED:

☐ COVID VACCINE DOSE #1

☐ COVID VACCINE DOSE #2

☐ COVID VACCINE DOSE #3

☐ COVID VACCINE Booster Dose #1

☐ COVID VACCINE Booster Dose #2

(VIS Date 8/12/2021) English / Spanish

ADDITIONAL DOSE CRITERIA

Moderately to Severely Immunocompromised

☐ Yes ☐ No

PATIENT CONSENT/ASSIGNMENT OF BENEFITS/RELEASE FOR TPO

- **The Notice of Privacy Practices describes how Johnston County Health Department may use or disclose information about you. Johnston County is required to give you notice of our privacy practices for the information we collect and keep about you. I have been given a copy of Johnston County's Notice of Privacy Practices and have been informed about the intent of the document. I also understand that if I have questions concerning this document I will be provided opportunity for further explanation upon request.**
- **I have read or have had explained to me information about the above listed immunizations, vaccines, or injections. I have received a copy of the VIS statement & I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the listed immunizations, vaccines, or injections, and request that they be administered to me or to the person named above for whom I am authorized to make this request.**
- **I request that payment of authorized Insurance Companies and/or Payor's, should I receive these services, be made to Johnston County Public Health Department for providing the Covid 19 Vaccine.**
- **I, do hereby swear that I am 18 years or older and have given consent to Johnston County Public Health Department to administer the above vaccine and/or have given my verbal consent for this registration form to be signed on my behalf.**

Patient/Guardian Consent _____ **Date** _____

Verbal Consent by: _____ **Witness:** _____ **Date** _____

Relationship: _____

ALLERGIES:	VACCINE PREPARED BY

IMM/VACCINE/INJECTION		INJECTION SITE	MANUFACTURER/LOT NO.	VACCINE ADMIN BY
COVID 19 Z23 / 91301 Moderna Z23 / 91306 Booster	Z23 / 91300 Pfizer Z23 / 91305 Comirnaty Z23 / 91303 Johnson & Johnson	L - R DELT		

Updated (03/31/2022) **Vaccine Admin Fees:** Moderna 1st 0011A 2nd 0012A 3rd 0013A Booster#1 0064A Booster#2
Pfizer 1st 0001A 2nd 0002A 3rd 0003A Booster#1 0004A Booster#2
Comirnaty 1st 0051A 2nd 0052A 3rd 0053A Booster 0054A
J & J 0031A Booster 0034A

☐ CVMS ☐ Immu.Cmd