Date: _____

Report #: _____

Location: _____

_____

_____

MONMOUTH COUNTY HEALTH DEPARTMENT (MCHD)

50 East Main St
Freehold, NJ 07728 TEL: 732-431-7456

Adult

EUA Date: _____

EUA Date Given: _____

NJIIS# _____

1st Dose _____

Mfr./Lot _____

2nd Dose _____

Mfr./Lot _____

Admin. by MCHD? Y N

Section 1: (PLEASE PRINT)

LAST NAME	(FIRST)	(M.I.)	DATE OF BIRTH
			___/___/___ (month) (day) (year)

MAILING ADDRESS	CITY	STATE	ZIP	GENDER (circle one)
				M F Other

Race:	Ethnicity	PHONE
	Hispanic: ☐ Non-Hispanic: ☐	

Section 2: Insurance

PRIMARY INSURANCE:	SECONDARY INSURANCE:
INSURANCE ID:	INSURANCE ID:

☐ No Insurance

Section 3: Consent for Vaccination

I authorize the submission of a claim to Medicare, Medicaid or any other payer for the services provided to me by MCHD now, in the past, or in the future, until I revoke this authorization in writing by certified mail. I understand that an insurance claim will not be submitted if I elected to opt out of insurance billing. I agree to immediately remit to MCHD any payment that I receive directly from insurance or any source for the services provided to me and I assign all rights to such payments to MCHD. I authorize MCHD to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical insurance, billing or other relevant information about me to release such information to MCHD and its billing agents, the Centers for Medicare and Medicaid Services and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by MCHD, now, in the past or in the future. I also authorize MCHD to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information. I/We request payment of any medical insurance benefits to go directly to MCHD. I/We permit a copy of this authorization to be used in place of the original. A copy of this form is as valid as the original. I have received the Emergency Use Authorization for the current Covid-19 vaccine and understand the risks and benefits. Immunizations provided thru this Federal and State Program will be registered in NJIIS (NJ Immunization Information System).

I give consent to the *Monmouth County Health Department* to administer the Covid-19 vaccine to me or the person named above for whom I am authorized to give consent, as his/her parent/legal guardian.

Signature _____ **Date:** _____

(Print) _____ **Relationship:** _____

FOR *ADMINISTRATIVE* USE ONLY

Vaccine	Date Administered: 1st Dose	2nd Dose	3rd Dose	Staff Signature	Vaccine Manufacturer Lot Number & Exp
COVID-19	IM R L Arm Leg	IM R L Arm Leg	IM R L Arm Leg		

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

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.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Have you received a complete COVID-19 vaccine series *(i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])*?	☐	☐	
• Did you bring your vaccination record card or other documentation?	☐	☐	
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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following: ○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists