North Central District Health Department
1020 Henry Clay Street
Shelbyville, Kentucky 40065

PEF label

DOCUMENT#: _____

HID/LOC/SITE: _____

3rd Dose COVID-19 VACCINE ADMINISTRATION RECORD

NAME: _____**ID/SOCIAL SECURITY#:** _____

ADDRESS: _____
STREET *CITY* *COUNTY* *STATE* *ZIP*

BIRTHDATE: _____/_____/_____ **PHONE NUMBER:**_____
MONTH DAY YEAR

RACE: (Check ONE or MORE) ☐ **(W)** White ☐ **(B)** Black or African American ☐ **(N)** American Indian or Alaska Native*****
☐ **(A)** Asian ☐ **(H)** Native Hawaiian or Other Pacific Islander **ETHNICITY:** Hispanic or Latino ☐Yes **or** ☐ No

SEX: (Check ONE) ☐Male ☐Female **How many in HOUSEHOLD:** ___ **Annual INCOME: $**_____ ☐**Income *NOT* Given**

DO YOU HAVE **MEDICAID**? ☐YES***** ☐NO IF YES, **MEDICAID NUMBER**: _____

DO YOU HAVE **MEDICARE**? ☐YES ☐NO IF YES, **MEDICARE NUMBER**: _____

DO YOU HAVE **HEALTH INSURANCE**? ☐YES ☐NO***** IF YES, **COMPANY NAME:** _____
Policy#_____ **Subscriber Name**_____**Group#**_____

The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

I attest that I am immunocompromised and am eligible for a third dose of vaccine based on the criteria below

- **Receiving active cancer treatment for tumors or cancers of the blood;**
- **Received an organ transplant and am taking medicine to suppress my immune system;**
- **Received a stem cell transplant within the last 2 years or am taking medicine to suppress the immune system;**
- **Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, WiskottAldrich syndrome);**
- **Advanced or untreated HIV infection;**
- **Active treatment with high-dose corticosteroids or other drugs that suppress my immune response.**

Having met the criteria, I am requesting the 3rd dose of (circle one) Pfizer or Moderna and it has at least 28 days since my last dose of the (circle one) Pfizer or Moderna vaccine.

I request that payment of authorized medical insurance benefits be made to _____ on my behalf or behalf of my child, for services received. I also authorize the local health department to release medical information to Medicare, Other Third Payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. I am aware that should Medicare refuse payment for this service, I will be responsible for the cost. If I am covered by a billable private insurance, I am aware that I may be responsible for some additional charges not covered by my plan.

X_____ **DATE:** _____
Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian/representative)

FOR HEALTH DEPARTMENT USE ONLY

Vaccine Manufacturer:_____**Vaccine Lot Number:**_____**Injection Site:**_____
Signature and Title of Provider:_____ **Provider# :**_____
NOTES: _____ **ICD Code: Z23.** Encounter for immunization

√	COVID-19 VACCINE:	√	ADMINISTRATION:
	91300-Pfizer Vaccine		0003A – 3rd Dose of Pfizer
	91301-Moderna Vaccine		0013A – 3rd Dose of Moderna
	80000 Unspecified Procedure		