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

# COVID-19 VACCINE ADMINISTRATION RECORD

PEF label

*DOCUMENT#:* _____

*HID/LOC/SITE:* _____

**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#**_____

**YOU or YOUR CHILD ARE LESS THAN 19yrs old AND HAVE HEALTH INSURANCE COVERAGE:**

☐ **YES,** the insurance does cover vaccines; ☐ **NO,** the insurance does not cover vaccines ***** **** VFC eligible***

**I request that payment of authorized medical insurance benefits be made to North Central District Health Department 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.**

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's special 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.**

**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 – SARS-CoV-2 COVID-19 0.3mL | | 0001A - 1st Dose |
| | 91300 – Pfizer – SARS-CoV-2 COVID-19 0.3mL | | 0002A - 2nd Dose |
| | 91301 – Moderna –SARS-CoV2 COVID-19 0.5mL | | 0011A - 1st Dose |
| | 91301 – Moderna –SARS-CoV2 COVID-19 0.5mL | | 0012A - 2nd Dose |
| | 91303 – Janssen – SARS-CoV2 COVID-19 0.5mL | | 0031A - Single Dose |
| | **80000 Unspecified Procedure** | | |
| | | | |

## Self-Attestation (Required for 3rd additional dose or Booster dose only

**3rd & Additional Dose: 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.**

**Booster Dose: I attest that I meet one of the following criteria as defined by the CDC and ACIP**

- **65 years or older**
- **Residents in long term care setting**
- **18-64 years old with underlying medical condition described by the CDC guidance**
- **18 years or older with increased exposure due to occupational or institutional exposure**

**Having met the criteria, I am requesting the 3rd or additional dose of (circle one) Pfizer or Moderna or the booster dose of (circle one) Pfizer, Moderna and it has been _____ days at least since my last dose of the (circle one) Pfizer, Moderna or J&J vaccine.**

**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 – SARS-CoV-2 COVID-19 0.3mL | | 0003A - 3rd Dose |
| | 91300 – Pfizer – SARS-CoV-2 COVID-19 0.3mL Booster | | 0004A - Booster |
| | 91301 – Moderna –SARS-CoV2 COVID-19 0.5mL | | 0013A - 3rd Dose |
| | 91306 – Moderna – SARS-CoV2 COVID-19 0.25 mL | | 0064A - Low 0.25mL Booster Dose |
| | 91303 – Janssen – SARS-CoV2 COVID-19 0.5mL | | 0034A - Booster Dose |
| | **80000 Unspecified Procedure** | | |

# Pediatric (Ages 5-11) COVID-19 Vaccine:

**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: |
|---|---|---|---|
| | 91307 – Pfizer – SARS-CoV2 0.2mL TRS-SUCR–PED | | 0071A - 1st Pediatric (5-11years) 0.2mL Dose |
| | 91307 – Pfizer – SARS-CoV2 0.2mL TRS-SUCR–PED | | 0072A - 2nd Pediatric (5-11 years) 0.2mL Dose |
| | **80000 Unspecified Procedure** | | |
| | | | |