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

PEF label

DOCUMENT#: _____

HID/LOC/SITE: _____

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#** _____

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

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.

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 understand that I will be under no financial obligation for this vaccine or any administrative fee as an individual.

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

County Administering: ☐ Henry ☐ Shelby ☐ Spencer ☐ Trimble

√	COVID-19 VACCINE:	√	ADMINISTRATION:
☐	91300 – Pfizer – SARS-CoV-2 COVID-19 0.3mL	☐	1st Dose – 0001A
		☐	2nd Dose – 0002A
☐	91301 – Moderna –SARS-CoV2 COVID-19 0.5mL	☐	1st Dose – 0011A
		☐	2nd Dose – 0012A

Patient Signature X _____