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

PEF label

3rd Dose & Booster
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#**_____

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.

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 dose of (circle one) Pfizer or Moderna or the booster dose of Pfizer and it has been _____ days at least since my last dose of the (circle one) Pfizer, J&J, 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 provider 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)

Vaccine Manufacturer: Sanofi GlaxoSmith Kline 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 OR Booster Dose of Pfizer
	91301-Moderna Vaccine		0013A – 3rd Dose of Moderna
	91303 – Janssen – SARS-CoV2 COVID-19 0.5mL		
	80000 Unspecified Procedure		