

Date: _____

MONMOUTH COUNTY HEALTH DEPARTMENT (MCHD)

NJIS# _____

Report #: _____

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

Adult

EUA Date: _____

Section 1: (PLEASE PRINT)

EUA Date Given: _____

1st Dose	_____
Mfr./Lot	_____
2nd Dose	_____
Mfr./Lot	_____
Admin. by MCHD?	Y N

LAST NAME	(FIRST)	(M.I.)	DATE OF BIRTH ____/____/____ (month) (day) (year)	
MAILING ADDRESS		CITY	STATE	ZIP
		GENDER (circle one) M F Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Race:	Ethnicity	PHONE		
_____	Hispanic: <input type="checkbox"/> Non-Hispanic: <input type="checkbox"/>	_____		

Section 2: Insurance

PRIMARY INSURANCE: _____	SECONDARY INSURANCE: _____
INSURANCE ID: _____	INSURANCE ID: _____
<input type="checkbox"/> 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 NJIS (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: _____			Staff Signature	Vaccine Manufacturer Lot Number & Exp
	1 st Dose: _____ ml	2 nd Dose: _____ ml	3 rd Dose: _____ ml		
COVID-19	IM R L Arm Leg	IM R L Arm Leg	IM R L Arm Leg		

Prevaccination Checklist for COVID-19 Vaccination



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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> If yes, which vaccine product(s) did you receive? 			
<input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product _____			
<ul style="list-style-type: none"> How many doses of COVID-19 vaccine have you received? _____ 			
<ul style="list-style-type: none"> Did you bring your vaccination record card or other documentation? 	<input type="checkbox"/>	<input type="checkbox"/>	
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? <i>(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had an allergic reaction to:			
<i>(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.)</i>			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> A previous dose of COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(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.)</i>			
7. Check all that apply to you:			
<input type="checkbox"/> Am a female between ages 18 and 49 years old			
<input type="checkbox"/> Am a male between ages 12 and 29 years old			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
<input type="checkbox"/> Have a bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Am currently pregnant or breastfeeding			
<input type="checkbox"/> Have received dermal fillers			
<input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS)			

Form reviewed by _____

Date _____

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