

Date: _____

MONMOUTH COUNTY HEALTH DEPARTMENT (MCHD)

NJIS# _____

Report #: _____

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

Location: _____

Adult

Health Dept.

EUA Date: _____

Section 1: (PLEASE PRINT)

EUA Date Given: _____

LAST NAME		(FIRST)	(M.I.)	DATE OF BIRTH ____/____/____ (month) (day) (year)	
MAILING ADDRESS		CITY	STATE	ZIP	GENDER <small>(circle one)</small> F or M or N
SSN <small>(optional)</small> □ □ □ □ □ □ □ □ □ □			PHONE		

Section 2: Insurance (Do not complete)

_____	_____
_____	_____
<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 COVID-19	Date <u>1st Dose</u> Administered	Date <u>2nd Dose</u> Administered	Route/Site		Staff Signature	Vaccine Manufacturer	Lot Number/ Exp Date
			1st Dose	2nd Dose			
COVID-19			IM R <input type="checkbox"/> L <input type="checkbox"/> Arm <input type="checkbox"/> Leg <input type="checkbox"/>	IM <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Arm <input type="checkbox"/> Leg			

Pre-Vaccination Checklist for COVID19- Vaccines



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.

Patient Name: _____

Age: _____

	YES	NO	Don't Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
****If Yes, which vaccine product?			
<input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Another Product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or an EpiPen, for which you had to go to the hospital			
<ul style="list-style-type: none"> Was the severe allergic reaction after receiving a COVID-19 vaccine? Was the severe allergic reaction after receiving another vaccine or another injectable medication? 			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened Immune system caused by something such as HIV Infection or cancer or do you take Immunosuppressive drugs or therapies			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Form reviewed by: _____ Date: _____