

Date: _____

MONMOUTH COUNTY HEALTH DEPARTMENT (MCHD)

NJIS# _____

Report #: _____

50 East Main St
Freehold, NJ 07726, TEL: 732-431-7456

Location: _____

Adult



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>
Race:	Ethnicity		PHONE		
	Hispanic:				
	Non-Hispanic:				

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 COVID-19	Date 1st Dose Administered	Date 2nd Dose Administered	Route/Site				Staff Signature	Vaccine Manufacturer	Lot Number/ Exp
			1st Dose		2nd Dose				
COVID-19			IM		IM				
			R	L	R	L			
			Arm	Leg	Arm	Leg			

Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

Patient Name _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

Age _____

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.

Yes No Don't know

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
<ul style="list-style-type: none"> If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another product _____ 			
3. Have you ever had an allergic reaction to:			
(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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine including either of the following: <ul style="list-style-type: none"> <input type="radio"/> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures <input type="radio"/> Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids. A previous dose of COVID-19 vaccine. A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction. 			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
(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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by _____

Date _____