Patient Label

Recipient Registration
COVID-19 Vaccine Administration Form

CVMS: ______ (Initials)

BIVALENT BOOSTER

AGE: (MUST BE 12 YEARS OR OLDER)

Recipient Full Name: ____**Date of Birth** ____/_____/______

Recipient Email Address: ____ ☐ No email

Have you already registered in the COVID-19 Vaccine Portal? ☐ Yes ☐ No

Home Phone Number: _______________________________**Mobile Phone Number:** ___________________________

Address: ____ **City:** ____________________________________

Zip Code: ___________________ **County:** ____**State:** ________________

Best way to contact you: ☐ SMS/Text Message ☐ Email ☐ Both ☐ None

Recipient Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Recipient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Recipient Gender: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify

Preferred Language: ☐ English ☐ Vietnamese ☐ Arabic ☐ French
☐ Spanish ☐ Hindi ☐ Other ☐ Decline to state

Disabilities: ☐ Not Disabled ☐ Cancer ☐ Cognitive (Psychological or Psychiatric)
☐ Neurological ☐ Physical (Mobility) ☐ Respiratory
☐ Sensory (Vision or Hearing) ☐ Other (Please Specify: _______________________)

_____I CERTIFY THAT I AM: (a) at least 18 years of age or older; or (b) the legal guardian of the patient. Further, I hereby give my consent to Brunswick County Health Services to administer the Covid-19 vaccine and share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

THE VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE INSURANCE OR NOT.
I understand my signature serves as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to BCHS for vaccine administration services rendered.

RECIPIENT/PARENT/GUARDIAN SIGNATURE ____________________________________

PREVACCINATION CHECKLIST FOR COVID-19 VACCINES RECIPIENT AGE: (MUST BE 12 YEARS OR OLDER)	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 did you receive? □ Pfizer □ Moderna □ Janssen □ Other: • How many doses have you received?			
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematocrit therapy [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*			
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?			
5. 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.)*			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), found in some medications, such as laxatives and preparations for colonoscopy procedure			
• Polysorbate, found in some vaccines, film coated tablets, and intravenous steroids			
• A previous dose of COVID-19 vaccine			
6. 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]*			

7. Check all that apply to you:

☐ Had a severe allergic reaction (e.g., anaphylaxis) to anything (food, animals, venom, environmental, or medications)?

☐ History of myocarditis or pericarditis

☐ History of multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a Covid -19 infection

☐ History of an immune-mediated syndrome with thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT), OR history of thrombosis with thrombocytopenia syndrome (TTS)

☐ History of Guillain-Barré Syndrome (GBS)

☐ History of prior Covid-19 disease or (+) test Date: ___________________

(may consider delaying booster doses for 3 months following infection)

OFFICE USE ONLY (VACCINE ADMINISTRATION INFORMATION)

☐ **Consent for COVID-19 Vaccine Obtained**

COVID-19 Vaccine Manufacturer Lot #: **Exp:**

Dose: ☐ **PFIZER** Bivalent Booster Dose 0.3mL (CPT-0124A / 91312)

☐ **MODERNA** Bivalent Booster Dose 0.5 mL (CPT-0134A / 91313)

Administration Date: ______________________ **Administration Time:** ______________________

Site of Injection: ☐ Left Deltoid, IM ☐ Right Deltoid, IM ☐Other________________

Vaccine administered by (Print Name) ___________________________ **Signature**_____________________________

Vaccination Site: ☐ BCHS **Other:** ☐ Homebound ☐ Outreach ☐ Contract/Volunteer Staff

Vaccinating Clinic Name: Brunswick County Health Services ☐ Supervised by Stacie Holmes, RN

Clerical
Demo/Ins___________ (Init)
Date _______________