Alexander County Public Health

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Approved Phase:

Phase 1 a	Phase 1b	Phase 2	Phase 3	Phase 4	Walk-In/prevent waste Dose
	Group 1	Group 1			
	Group 2	Group 2			
	Group 3	Group 3			
		Group 4			

1st Vaccination Consent:

***STATEMENT OF PERMISSION AND ASSIGNMENT*:**
I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on my behalf, and I authorize payment to the provider for such claim

I have been informed that if my Medicare or private Insurance does not pay, I will not be charged or billed in the future for anything related to the COVID-19 vaccine.

_____ _____
(Date) (Patient Signature)

2nd Vaccination Consent

***STATEMENT OF PERMISSION AND ASSIGNMENT*:**
I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on my behalf, and I authorize payment to the provider for such claim

I have been informed that if my Medicare or private Insurance does not pay, I will not be charged or billed in the future for anything related to the COVID-19 vaccine.

_____ _____
(Date) (Patient Signature)

Pfizer BioNTech

Schedule	Date	Site	Time	Lot #	Exp. Date	Vaccinator Initials	Billing Code
1st Dose							0001A
2nd Dose							0002A

Moderna

Schedule	Date	Site	Time	Lot #	Exp. Date	Vaccinator Initials	Billing Code
1st Dose							0011A
2nd Dose							0012A

Insurance Information: Check what applies and present copy of card
□No insurance
□Medicare (CMS Part B only)(S-2) - ID# _____(must end with a letter)
□ NC Medicaid (R-1) - ID# _____ Effective Date: ___-___-____
□ NC Health Choice (R-NCHC) - ID# _____ Effective Date: ___-___-____
□ Commercial Insurance or Medicare Advantage Plan (5) - ID# _____
□ Employer/Group (Z) - Name of Employer _____ Group # _____

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COVID-19 Vaccine Encounter Form

Client Name: _____ **Date of Birth:** ___-___-_____ **Age:**_____

Client SS#:___-___-_____ **Race Sex:** □ **Male** □ **Female** **Telephone:** (___)_____-_____ **Mobile or landline**

Ethnicity: (check all that apply) **How do you prefer to be contacted:** _____

□ **White** □ **Black/African Amer.** □ **Amer Ind/AK Native** □ **Asian** □ **Native HI/other PI** □ **Unknown**

□ **Other** _____ **Email:** _____

Client Address: _____
(Street/Apt) (City) (State) (Zip Code)

Employed: □ **Yes** □ **No** □ **Retired** □ **Student** _____(School)

If yes to employed list where/position: _____

How many conditions known to increase risk of severe illness form COVID-19 do you have?
□ **None** □ **1** □ **2 or more**

Questions 1-3 require consultation with a medical provider if the answer is Yes or Don't Know.	**YES**	**NO**	**Don't Know**
Are you feeling sick today? (Circle all that apply) Moderate Acute Illness (list) Severe Acute Illness (list) Current COVID-19 Infection (Date Diagnosed: _____) List any other symptoms you have right now:_____			
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 EpiPen®, or for which you had to go to the hospital?			
Was the severe allergic reaction after receiving a COVID-19 vaccine?			
Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
Have you ever received a dose of COVID-19 vaccine? If so, which vaccine did you receive: ☐ Pfizer ☐ Another vaccine product (Name of Vaccine Product: _____)			
Questions 4 requires consultation with a medical provider if the answer is Yes.	**YES**	**NO**	**N/A**
If you have received a trial vaccine as a part of a COVID-19 vaccine trial, has your trial sponsor determined it is feasible to receive additional doses? If yes, Name of vaccine received _____ Number of doses received _____			
Questions 5-9 require additional nursing interventions as defined in the Standing Order.	**YES**	**NO**	
Do you have a bleeding disorder or are you taking a blood thinner?			
Have you received passive antibody therapy as treatment for COVID-19? Date patient received passive antibody therapy: _____			
Are you Immunocompromised (e.g., has cancer, has leukemia, has HIV/AIDS, other immune system problems or taking medication that affects your immune systems, etc.)?			
Are you pregnant or planning to become pregnant?			
Are you breastfeeding?			