Recipient Registration and COVID-19 Vaccine Administration Form

Recipient Full Name: ____**Date of Birth** _____/_____/______
Recipient Email Address: ____ ☐ No email
Have you already registered in the CVMS Recipient Portal? ☐ Yes ☐ No
Home Phone Number: ___________________________ **Mobile Phone Number:** _________________________
Address: ____ **City:** _________________________________
Zip Code: ________________ **County:** _____________________________________**State:** _______________
What is the name of the organization you work for (or reside in)? ________________________ ☐ Not employed
If employed, in what industry do you work? (healthcare, food and agriculture, manufacturing, education, etc.)
____

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

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

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

Do you identify as any of the following?

☐ Frontline essential worker (in person at work)
☐ Other essential worker (non-frontline)
☐ Patient-facing healthcare worker or long-term care facility worker
☐ School and child care frontline essential worker
☐ Resident of a congregate/group setting
☐ Resident of a long-term care facility
☐ Student
☐ None of the above

How many conditions do you have that put you at risk for developing severe illness from COVID-19?
☐ None ☐ 1 ☐ 2 or more

☐ **I certify that I am**: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an 'applicable Provider'), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

Recipient signature ____

OFFICE USE ONLY

☐ **Verbal Consent for COVID-19 Vaccine Obtained**
Site of Injection: ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐Other________________
Dose: ☐ First Dose ☐ Second Dose
Administration Date: _____/_____/__________
Administration Time: ____________________
COVID-19 Vaccine Manufacturer: ____________________________
Lot #: ____________________________ **Exp:** _____/_____/_______

Manufacturer sticker (optional)

Vaccine administered by (Clinician Name)_________________________ **Signature**___________________________
Vaccinating Clinic Name____

Form Version 8 – 2/11/2021 – North Carolina COVID-19 Vaccine Management System

THE VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL.

If you have your insurance card with you today or if you are not insured, you do not need to fill out the insurance information.
INSURANCE INFORMATION/AUTHORIZATION TO BILL (copy of front and back of insurance card preferred for verification)

Insurance Name: ____________________________________ Member ID: ____

Group Number: _____________________________________ Phone Number: _____________________________________

Medical Claims Address: ____

Subscriber Name: ____Subscriber Date of Birth: _____/_____/________

Subscriber Address: ____

☐ I authorize payment from 3rd Party Payer (Insurance) and Medicare/Medicaid be made on my behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature above will serve as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to the licensed healthcare provider administering the vaccine for services rendered.

PREVACCINATION CHECKLIST FOR COVID-19 VACCINES

PLACEHOLDER

OFFICE USE ONLY (VACCINE BILLING INFORMATION)

1st Dose ☐	**91301-SL** (Moderna SARS-CoV-2 Preservative free vaccine) **0011A** (Administration of 1st dose of Moderna Vaccine) Dx z23	1st Dose ☐	**91300-SL** (Pfizer SARS-CoV-2 Preservative free vaccine) **0001A** (Administration of 1st dose of Pfizer Vaccine) Dx z23	1st Dose ☐	*For future use*
2nd Dose ☐	**91301-SL** (Moderna SARS-CoV-2 Preservative free vaccine) **0012A** (Administration of 2nd dose of Moderna Vaccine) Dx z23	2nd Dose ☐	**91300-SL** (Pfizer SARS-CoV-2 Preservative free vaccine) **0002A** (Administration of 2nd dose of Pfizer Vaccine) Dx z23		

Wilkes Health

COVID-19 Vaccination Screening Tool

Patients/individuals with respiratory symptoms such as fever, cough, shortness of breath should be given a mask to put on immediately.

SYMPTOMS

1. Does the patient/individual have:
   a. Fever_________ (100 or greater) Temp:__________________
   b. NEW Cough _________
   c. Shortness of breath ___________
   d. Chills _________
   e. NEW Loss of taste or smell __________

HISTORY

2. Are you 18 years old or older? (If no, please screen out and ask patient to take express lane.)

3. Have you had a previous allergic reaction to a vaccine?

   a. Yes______ (If yes, please tell patient to wait 30 minutes in the observation parking lot after receiving the vaccination.)
   b. No______ (If no, please tell patient to wait 15 minutes in the observation parking lot after receiving the vaccine.)

4. Do you have a bleeding disorder or are you taking a blood thinner? Yes_____ No_____

5. Have you been tested for COVID-19 in the past 30 days? (If yes, and no result or positive, please screen out)
   a. Yes_____, when__________________, result _______________
   b. No _________

6. Are you pregnant or breastfeeding?
   a. Yes____, (Do you have a Doctors order. If yes, ask to see it.)
   b. No_____

7. Have you ever received a dose of COVID-19 vaccine? If so, which vaccine did you receive:
   a. Pfizer _____ b. Moderna_______ When?____________________

Temp - 100 or above:

Screen out and ask them to go to the express lane and exit.

Temp – less than 100:

If patient has an appointment and their temperature is less than 100, instruct them to proceed to the registration tent.