COVID-19 VACCINE ADMINISTRATION FORM
Patient Encounter Form

Site: _____

Date: _____

Entered in KYIR: _____

Encounter # _____

PATIENT DEMOGRAPHICS

Name: _____
Last First Middle

ID/Social Security#: _____ Address: _____

Birthdate _____ Age _____ County _____ Cellphone _____

Gender: ☐ Male ☐ Female Hispanic/Latino ☐ **Y** ☐ **N** Email: _____

Race (check all that apply): ☐ White ☐ Black ☐ American Indian/Alaskan ☐ Hawaiian/Pacific Islander ☐ Asian ☐ Multiracial

Do you have Medicaid? ☐ Yes ☐ No Name of MCO: _____ Medicaid ID#: _____

FACILITY TYPE / OCCUPATION

Please check all that apply: ☐ HCW ☐ LTCF Staff ☐ LTCF Resident ☐ First Responder ☐ Shelter Resident / Staff ☐ School Teacher ☐ Home Health Staff ☐ Other _____

INFORMED CONSENT FOR VACCINES

Of my own free will, I consent to care which may include administration of vaccines, including any or all vaccines required for compliance with Kentucky State immunization requirements. I understand that no guarantees are being made as to the effect of any treatment given to me. I also understand I may be tested for HIV infection, Hepatitis B, or any other disease carried by blood or body fluids if such a test(s) is needed if a health care worker is exposed to my blood, body fluids or tissue.

I have read or had read to me information about the vaccines/service listed below. I had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of any vaccine(s) to be administered. I AUTHORIZE payment of insurance benefits to the **Boyle County Health Department** and give consent to release medical information to insurance companies or other agents.

X _____ _____ _____
Signature of Patient/Parent/Legal Guardian/Representative **Relationship** **Date**

I have received or been offered the HIPAA privacy notice **X** _____ **Date:** _____

EAU FACT SHEET

Vaccine: **COVID-19 VACCINE** Publication Date: _____ Date Received: _____

My **initials** here verify receipt of appropriate vaccine information statement: **X** _____

FOR CLINIC STAFF USE ONLY: Please complete all information below

Previous Vaccination: Vaccine: _____ Dose # _____ Date: _____ Due: _____

Has the patient ever had an allergic reaction to the vaccine or any of its components? ☐ **Y** ☐ **N** (If yes, don't vaccinate)

Is the patient moderately to severely sick today? ☐ **Y** ☐ **N** (If yes, don't vaccinate)

Temperature: _____

Is the patient pregnant? ☐ **Y** ☐ **N** (if yes, can vaccinate depending on vaccine)

Have you had any other vaccines in the past two weeks? ☐ **Y** ☐ **N** (if yes, don't vaccinate)

Injection site: ☐ **R or** ☐ **L Deltoid** Patient Refused: _____

Signature and Title of Provider: _____ **Provider #:** _____

	Description	CPT	Administration	ICD-10 Code	Manufacturer	Lot Number	Expiration
☐	**Unspecified Procedure**	**80000**					
☐	**Pfizer – SARS-CoV-2 COVID-19 0.3mL**	**91300**	**0001A -1st Dose**	**Z23**			
☐	**Pfizer – SARS-CoV-2 COVID-19 0.3mL**	**91300**	**0002A -2nd Dose**	**Z23**			
☐	**Moderna –SARS-CoV2 COVID-19 0.5mL**	**91301**	**0011A -1st Dose**	**Z23**			
☐	**Moderna –SARS-CoV2 COVID-19 0.5mL**	**91301**	**0012A -2nd Dose**	**Z23**			
☐	**Janssen – SARS-CoV2 COVID-19 0.5mL**	**91303**	**0031A-SINGLE Dose**	**Z23**			