The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

**Information about the person to receive vaccine** (please print): \*Required Fields

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: (Last, First, MI)\* | | Date of birth: \*  \_\_\_\_\_ \_\_\_\_ \_\_\_\_\_  Month Day Year | | | Age\* | Sex: (Circle)\*  Male Female |
| Street Address:\* | | | | | | |
| City:\* | State: \* | | Zip:\* | Phone:\*  ( ) | | |

**Insurance Information:** Include the whole member ID number and any letters that are part of that number

|  |  |  |
| --- | --- | --- |
| Name of Insurance Company:\* | Member ID Number:\* | Group ID Number: (if available) |

**If person getting vaccinated is not the insurance subscriber/policy holder, please complete the following:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Subscriber’s Name: (Last, First, MI)\* | | | Subscriber’s Date of Birth: \*  \_\_\_\_\_ \_\_\_\_ \_\_\_\_\_  Month Day Year | | Sex: (Circle)\*  Male Female |
| Subscriber’s Street Address:\* (If different from address above) | | | | | |
| City:\* | State:\* | Zip: \* | | Phone:\*  ( ) | |
| Patient Relationship to Subscriber: (Circle)\* Spouse Child Other | | | | | |

In signing this form, I agree that:

1. The information I provided is correct.
2. I have been provided the COVID-19 EUA Fact Sheet for Recipients and Caregivers which has information about the risks and benefits of the vaccine. I will be able to ask questions at the time I receive my immunization.
3. I have the legal authority to and give consent for me and any other person(s) I registered to be vaccinated with the vaccine(s) above.
4. I give permission for my insurance company to be billed for the costs of administering the vaccine(s).  The government is paying for the vaccine itself and I will not be billed for that portion of the cost of my immunization.
5. I understand that as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS).  I can access the MIIS factsheet for Parents and Patients, at [www.mass.gov/dph/miis](http://www.mass.gov/dph/miis), for information on the MIIS and what to do if I object to my or my family's data being shared with other providers in the MIIS.

X \_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of patient, parent or legal guardian)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| COVID-19 Vaccine | **Type of Vaccine\*** | Date of Service | Dose (mL) | Route (IM) | **Site**  (RA,LA,RT,LT) | **Vaccine** | |  | **EUA** | |
| lot # | mfr. | Expir.  Date | Date on  EUA Factsheet | Date  EUA Factsheet Given |
| Pfizer-BioNTech COVID-19  Moderna COVID-19 |  |  |  | IM |  |  |  |  |  |  |

Signature of Vaccine Administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MDPH Provider PIN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_