

LHD name

LHD address

PEF label

DOCUMENT#:

HID/LOC/SITE:

# 3<sup>rd</sup> Dose COVID-19 VACCINE ADMINISTRATION RECORD

NAME: ID/SOCIAL SECURITY#:

ADDRESS:

STREET CITY COUNTY STATE ZIP

BIRTHDATE: / / PHONE NUMBER:

MONTH DAY YEAR

RACE: (Check ONE or MORE) ☐ (W) White ☐ (B) Black or African American ☐ (N) American Indian or Alaska Native\*☐ (A) Asian ☐ (H) Native Hawaiian or Other Pacific Islander ETHNICITY: Hispanic or Latino ☐ Yes or ☐ NoSEX: (Check ONE) ☐ Male ☐ Female How many in HOUSEHOLD: Annual INCOME: \$ ☐ Income NOT GivenDO YOU HAVE MEDICAID? ☐ YES\* ☐ NO IF YES, MEDICAID NUMBER:DO YOU HAVE MEDICARE? ☐ YES ☐ NO IF YES, MEDICARE NUMBER:DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO\* IF YES, COMPANY NAME:

Policy# Subscriber Name Group#

YOU or YOUR CHILD ARE LESS THAN 19yrs old AND HAVE HEALTH INSURANCE COVERAGE:

The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

I attest that I am immunocompromised and am eligible for a third dose of vaccine based on the criteria below

- Receiving active cancer treatment for tumors or cancers of the blood;
- Received an organ transplant and am taking medicine to suppress my immune system;
- Received a stem cell transplant within the last 2 years or am taking medicine to suppress the immune system;
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, WiskottAldrich syndrome);
- Advanced or untreated HIV infection;
- Active treatment with high-dose corticosteroids or other drugs that suppress my immune response.

Having met the criteria, I am requesting the 3<sup>rd</sup> dose of (circle one) Pfizer or Moderna and it has been \_\_\_\_\_ days at least since my last dose of the (circle one) Pfizer or Moderna vaccine.

I request that payment of authorized medical insurance benefits be made to \_\_\_\_\_ on my behalf or behalf of my child, for services received. I also authorize the local health department to release medical information to Medicare, Other Third Payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. I am aware that should Medicare refuse payment for this service, I will be responsible for the cost. If I am covered by a billable private insurance, I am aware that I may be responsible for some additional charges not covered by my plan.

X

DATE:

Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian/representative)

## FOR HEALTH DEPARTMENT USE ONLY

Vaccine Manufacturer: Vaccine Lot Number: Injection Site:

Signature and Title of Provider: Provider#:

NOTES: ICD Code: Z23. Encounter for immunization

COVID-19 VACCINE:	ADMINISTRATION:
<input checked="" type="checkbox"/> 91301- Moderna Vaccine 0.5ml IM	<input checked="" type="checkbox"/> 0013A - 3 <sup>RD</sup> Dose of Moderna
<input type="checkbox"/> 91306- Moderna Vaccine 0.25ml IM	<input type="checkbox"/> 0064A - Low Dose Moderna Booster
<input type="checkbox"/> 91303- Janssen Vaccine 0.5ml IM	<input type="checkbox"/> 0031A - 2 <sup>ND</sup> Dose of Janssen
<input type="checkbox"/> 80000- Unspecified Procedure	

Patient Signature X