COVID-19 VACCINATION - PATIENT INFORMATION Today's Date_____

Name_____ DOB: _____ M F Age: _____

Parent/Guardian Name (if applicable) _____

Home Phone_____ Cell Phone _____ Email _____

Mailing Address_____City_____ZIP_____

Race/Ethnicity (circle all that apply): White Black/African American American Indian/Alaska Native
Asian Hispanic/Latino Other

INSURANCE – *Please mark what applies for the patient.*

☐ Private Insurance Company Name _____
ID Number _____ Group Number_____
Policy Holder Name _____ DOB _____

☐ Medicare ID Number _____

☐ Medicaid/ Healthy Montana Kids Plus ID Number _____

☐ Healthy Montana Kids (BCBS) ID Number _____

☐ No health insurance

☐ Insurance does not cover vaccines

☐ Unable to pay for vaccines

☐ American Indian/ Alaska Native

Consent to treat: I authorize the Teton County Health Department providers to administer treatment as deemed necessary for care of the above-named patient. I certify that I am the above-named patient or the parent or legal guardian of the patient.
Assignment of benefits: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient/parent/responsible party is responsible for any unpaid balances or co-payments. I request that payment of authorized Medicare, Medicaid or other insurance company benefits be made to Teton County Health Department for any services provided to me or the above-named patient. My signature indicates that all information provided is true and accurate:

_____ _____
Signature of Patient or Legal Representative Today's Date

IMMTRAX CONSENT

I authorize my health care provider and a public health agency to collect and enter my or my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my or my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

_____ _____
Signature of Patient or Legal Representative Today's Date

Turn Page Over

The following questions will help determine which vaccines should be given today. **If you answer "yes" to any question, it does not necessarily mean the vaccine should not be given,** it just means additional questions should be asked. If you do not understand a question, please ask someone in the health department for clarification.

Is the person who is having the immunization:	**Yes**	**No**	**Don't Know**
1. Sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. 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 reaction after receiving another vaccine or another injectable medication?	☐	☐	☐
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
5. Have you received another vaccine in the last 14 days?	☐	☐	☐
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
8. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
9. Are you pregnant or breastfeeding?	☐	☐	☐

FOR OFFICE USE

Form reviewed by: _____ Date: _____

Vaccine Manufacturer: Moderna

Vaccine Lot Number: _____

Date Vaccine Administered: _____

Site of Injection: _____

Signature of Vaccine Administrator: _____

Notes: