

**PERSONAL AND CONTACT INFORMATION** (Please fill out ALL the information below)

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First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

Maiden Name: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Email: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

**Communication Preference:**

- |                                       |                               |
|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Email        | <input type="checkbox"/> Both |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None |

**Race:**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian / Pacific Islander
- White
- Decline to answer

**Ethnicity:**

- Hispanic or Latino
- Not Hispanic or Latino

**Gender:**

- Male
- Female
- Decline to answer

**Are you an Essential Frontline Worker (Police, Food Processing, Teachers, etc.)?**

- Yes  No

If yes, what is the name of your employer? \_\_\_\_\_

**Do you reside or work in a long-term care/assisted living facility?**

- Yes  No

If yes, what is the name of the facility? \_\_\_\_\_

**Are you a member of a state or federal recognized tribal nation?**

- Yes  No

If yes, what is the name of the community? \_\_\_\_\_

**MEDICAL INFORMATION (Please fill out ALL the information below)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Review the below list of conditions known to increase risk of severe illness to COVID-19:

- Asthma
- Cancer
- Cerebrovascular Disease
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease
- Cystic Fibrosis
- Hypertension or High Blood Pressure
- Type 1 Diabetes Mellitus
- Type 2 Diabetes
- Immunocompromised from solid organ transplant
- Immunocompromised state (weakened immune system)
- Liver Disease
- Neurologic conditions, such as Dementia
- Obesity
- Overweight (BMI > 25 kg/m2, but < 30 kg/m2)
- Pregnancy
- Pulmonary Fibrosis (having damaged or scarred lung tissues)
- Sickle Cell Disease
- Smoker
- Thalassemia (a type of blood disorder)

**How many conditions known to increase risk of severe illness from COVID-19 do you have?**

- None
- 1
- 2 or more

**INSURANCE INFORMATION (Please fill out the information below)**

**(Circle all that apply) INSURANCE / MEDICAID / MEDICARE / MEDICARE ADVANTAGE/NONE**

Insurance Company Name: \_\_\_\_\_ Subscriber's ID (Policy Number): \_\_\_\_\_  
 Effective Date: \_\_\_\_\_ Group number: \_\_\_\_\_  
 Subscriber's Name (Policy Holder): \_\_\_\_\_ Subscribers Date of Birth: \_\_\_\_\_  
 Policy holder's employer: \_\_\_\_\_  
 Claims mailing address: \_\_\_\_\_ Benefits telephone number: \_\_\_\_\_

**CONSENT**

- 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. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available to me.
- I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of COVID 19 vaccine and request that the COVID19 vaccine be given to me or the person named above for whom I am authorized to make this request. I have been provided access to the Cabarrus Health Alliance Notice of Privacy Practices. I agree for Medicare, Medicaid and/or Insurance, if applicable, to be billed and I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the Cabarrus Health Alliance.
- I have been provided access to the Cabarrus Health Alliance Notice of Privacy Practices.  
<https://www.cabarrushealth.org/DocumentCenter/View/347/Notice-of-Privacy-Practices>

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Date

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month Day Year

**FOR OFFICIAL USE ONLY**

**\* Required Fields**

**\*Responsible Organization:** Cabarrus Health Alliance

"Responsible Organization" is the name of the parent organization or health system that originated and is accountable for the content of the record. If an organization has several clinics or facilities, this would be the organization that represents all of the clinics/facilities.

**\*Administration at Location:** Cabarrus Health Alliance **POD Site:** \_\_\_\_\_

"Administration at Location" is the name of the physical clinic or facility that reported the vaccination, refusal, or missed appointment. In a small practice setting, this could be the same as the responsible organization.

\*Administration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Administration Time: \_\_\_\_AM \_\_\_\_PM  
 Month Day Year

\* Vaccine Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month Day Year

\* Vaccine Barcode: \_\_\_\_\_

\*Vaccine Type (CVX): \_\_\_\_\_ \*Vaccine Manufacturer (MVX): \_\_\_\_\_

\*Vaccine Product (NDC): \_\_\_\_\_ \*Vaccine Lot Number: \_\_\_\_\_

\*Available Vaccine Inventory: \_\_\_\_\_

\*Vaccine administered on behalf of (Clinician): \_\_\_\_\_

<u>*Vaccine Administering Site</u>	<u>*Vaccine Route of Administration</u>	<u>*Dose Number</u>
____ Left Deltoid (LD)	____ Intramuscular (IM)	____ First Dose
____ Left Arm (LA)	____ Subcutaneous (SQ)	____ Second Dose
____ Left Lower Forearm (LLFA)		
____ Right Deltoid (RD)		
____ Right Arm (RA)		
____ Right Lower Forearm (RLFA)		
____ Left Thigh (LT)		
____ Left Gluteus Medius (LG)		
____ Left Vastus Lateralis (LVL)		
____ Right Thigh (RT)		
____ Right Gluteus Medius (RG)		
____ Right Vastus Lateralis (RVL)		

**Notes:**

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