

COVID-19 Recipient Vaccination Questionnaire

PERSONAL AND CONTACT INFORMATION

(Please fill out ALL the information below)

First Name: _____ Last Name: _____ Date of Birth: _____ / _____ / _____
Month Day Year

Email: _____ Social Security Number: _____ - _____ - _____

Street: _____

City: _____ County: _____

State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

DOSE INFORMATION

First Dose Manufacturer (Circle): Pfizer / Moderna First Dose Date: _____

Second Dose Manufacturer (Circle): Pfizer / Moderna Second Dose Date: _____

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) legally able to consent to my own health care G.S. 90-21.5 (c) the parent or legal guardian of the minor patient; or (d) 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)		___ Booster
___ 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:
