INSTRUCTIONS (DO NOT PRINT THIS PAGE)

PLEASE READ BEFORE PRINTING THE FORM:

- **If you use this document only to collect data needed in CVMS, please only print the page 1.** Do Not Change Document Spacing on the first page. It has been locked. This document has been created to match the flow of CVMS, simplify data entry and future data recognition capabilities.

- **If you need to collect insurance information and the CDC screening questions, you can also customize and print the page 2.** All tools on that page are customizable for your clinic requirements and needs. **Do not print the second page if unnecessary.**

ADDITIONAL INSTRUCTIONS TO ASSIST RECIPIENTS FILLING THE FORM

VERBAL CONSENT OBTAINED (Page 1):
The patient or legal guardian has been provided the benefits and potential adverse reactions and provides consent to receive the vaccine.
Administering healthcare providers must provide an approved Emergency Use Authorization (EUA) Fact Sheet as required to each vaccine recipient, the adult caregiver accompanying the recipient, or other legal representative.

PREVACCINATION CHECKLIST FOR COVID-19 VACCINES (Page 2):

You can include the CDC pre-vaccination screening questions or a local document on the customizable second page. Please download the latest version here:
https://www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf

Recipient Registration and COVID-19 Vaccine Administration Form

Recipient Full Name: _____**Date of Birth** _____/_____/_____

Recipient Email Address: _____ ☐ No email

Have you already registered in the COVID-19 Vaccine Portal? ☐ Yes ☐ No

Home Phone Number: _____**Mobile Phone Number:** _____

Address: _____ **City:** _____

Zip Code: _____ **County:** _____**State:** _____

Best way to contact you: ☐ SMS/Text Message ☐ Email ☐ Both ☐ None

Recipient Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Recipient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Recipient Gender: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify

Preferred Language: ☐ English ☐ Vietnamese ☐ Arabic ☐ French ☐ Spanish ☐ Hindi ☐ Other ☐ Decline to state

Disabilities: ☐ Not Disabled ☐ Cancer ☐ Cognitive (Psychological or Psychiatric) ☐ Neurological ☐ Physical (Mobility) ☐ Respiratory ☐ Sensory (Vision or Hearing) ☐ Other (Please Specify: _____)

☐ **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.

Recipient Signature _____

OFFICE USE ONLY

☐ **Verbal Consent for COVID-19 Vaccine Obtained**

Site of Injection: ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐Other_____

Dose: ☐ First Dose ☐ Second Dose

Route: ☐ Intramuscular ☐ Subcutaneous ☐ Intradermal

Administration Date: _____/_____/_____

Administration Time: _____

Vaccine Product: ☐ Moderna ☐ Pfizer ☐ Janssen

Lot #: _____ **Exp:** _____/_____/_____

Manufacturer sticker (optional)

Vaccine administered by (Clinician Name):_____ **Signature**_____

Vaccinating Clinic Name:_____

THE VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL.

If you have your insurance card with you today or if you are not insured, you do not need to fill out the insurance information.
INSURANCE INFORMATION/AUTHORIZATION TO BILL (copy of front and back of insurance card preferred for verification)

Insurance Name: _____ Member ID: _____

Group Number: _____ Phone Number: _____

Medical Claims Address: _____

Subscriber Name: _____Subscriber Date of Birth: _____/_____/_____

Subscriber Address: _____

☐ I authorize payment from 3rd Party Payer (Insurance) and Medicare/Medicaid be made on my behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature above will serve as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to the licensed healthcare provider administering the vaccine for services rendered.

PREVACCINATION CHECKLIST FOR COVID-19 VACCINES

PLACEHOLDER

OFFICE USE ONLY (VACCINE BILLING INFORMATION)

1st Dose ☐	**91301-SL** (Moderna SARS-CoV-2 Preservative free vaccine) **0011A** (Administration of 1st dose of Moderna Vaccine) Dx z23	1st Dose ☐	**91300-SL** (Pfizer SARS-CoV-2 Preservative free vaccine) **0001A** (Administration of 1st dose of Pfizer Vaccine) Dx z23	1st Dose ☐	**91302-SL** (Janssen SARS-CoV-2 Preservative free vaccine) **0031A** (Administration of 1st dose of Janssen Vaccine) Dx z23
2nd Dose ☐	**91301-SL** (Moderna SARS-CoV-2 Preservative free vaccine) **0012A** (Administration of 2nd dose of Moderna Vaccine) Dx z23	2nd Dose ☐	**91300-SL** (Pfizer SARS-CoV-2 Preservative free vaccine) **0002A** (Administration of 2nd dose of Pfizer Vaccine) Dx z23		