HENRY COUNTY PUBLIC health

COVID-19 Vaccine

Section 1: Vaccine Recipient Information (Please Print)

Recipient Name: _____
Last First M.I.

Any other last names vaccination records might be under: _____

Address: _____
Street City State Zip Code

Age:_____ Date of Birth:_____ ☐ Male ☐ Female

Would you benefit from calming tools (i.e. weighted lap blanket, cold spray, dimmed lights)? ☐ Yes ☐ No

Section 2: Screening for Vaccine Eligibility (for recipient)

Are you American Indian/Alaskan Native? ☐ Yes ☐ No

Are you currently sick today? ☐ Yes ☐ No

Are you immunocompromised (weakened immune system)? ☐ Yes ☐ No ☐ Don't Know

Have you ever had a severe allergic reaction to any vaccination? ☐ Yes ☐ No ☐ Don't Know

Check all that apply to the person to be vaccinated:

☐ Have a history of myocarditis or pericarditis

☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?

☐ None of the above

Section 3: Insurance Billing ☐ I do not have insurance ☐ My insurance does not cover vaccines

I, the undersigned, certify that the information given by me in applying for payment under the insurance I provided, is correct. I authorize release of all records required to act on their request and request that payment of authorized benefits be made on my behalf or all who may be covered by this insurance. I authorize such insurance to make payment directly to Henry County Public Health.

I also understand that if the insurance DOES NOT pay, I may be billed for today's services.

Insurance Company Name:_____ Insurance #: _____

Policy Holder Name:_____

Date of Birth: _____ ☐ Male ☐ Female

Signature: _____

Date: _____

Phone Number: _____

COVID VACCINE
Healthcare Provider Use Only

VFC VFA Insurance

Date: _____

Lot #: _____

Injection Site (Deltoid): ___ Left ___ Right

Administered by: _____