106 N. Jackson St, Suite 103, Mt. Pleasant, IA 52641

NOVAVAX

COVID-19 Vaccine Administration Record

I am: ☐ **12 years or older**

I am here for my: ☐ **1st Dose** ☐ **2nd Dose (1st dose must have been Novavax also)**

Date first dose administered: Month ____________ Day ______ Year ______

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

Date of Birth:____________ Age:____ Phone Number:________________ ☐ Male ☐ Female

Section 2: Screening for Vaccine Eligibility

Have you ever had a severe allergic reaction to any vaccination? ☐ Yes ☐ No

If you have previously received the COVID-19 vaccine, did you experience hives, wheezing/respiratory distress, or anaphylaxis within 4 hours of receiving your shot? ☐ Yes ☐ No ☐ N/A

Section 3: Consent

I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request. **I understand the person receiving the COVID-19 vaccine should remain in the clinic for 15 minutes after the vaccination.**

Signature:______________________________________ Date:____________________

Links to the COVID-19 Vaccine EUA Fact Sheets for Recipients are referenced on the CDC handout you received today and hard copies of the fact sheets are available upon request.

Healthcare Provider Use Only

Date Vaccine Administered: ________________ Injection Site (Deltoid): ☐ Left ☐ Right

Manufacturer: Lot #______________Exp: ________ Administered by: ____________

SEE BACK FOR INSURANCE INFORMATION

Insurance Billing

I, the undersigned, certify that the information given by me in applying for payment under the private 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.

Note: If your insurance does not pay, you WILL NOT be billed for any COVID-19 vaccine expense.

Insurance Company Name:___________________________________

Insurance #: ____

Name of Policy Holder: ____ Sex: M____ F____

Date of Birth of Policy Holder: _______________________

Signature: ____ Date: ________________