**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 the parent or legal guardian written consent for minors, 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**

**CONSENT OBTAINED (Page 1)**:

The individual receiving the vaccine, or their authorized representative was provided information consistent with the “Fact Sheet for Recipients and Caregivers” and consent was obtained prior to receiving the COVID-19 vaccine. Consent may be verbal, except written consent from a parent or legal guardian is required for a minor to receive a vaccine that is under emergency use authorization for the minor’s age group.

*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.*

**PRE-VACCINATION 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 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 [ ]  Additional Dose **Manufacturer sticker (optional)**

**Route:** [ ]  Intramuscular [ ]  Subcutaneous [ ]  Intradermal

**Administration Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Administration Time:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccine Product:** [ ]  Moderna [ ]  Pfizer [ ]  Janssen

**Lot #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Exp:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

**Vaccine administered by (Clinician Name):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccinating Clinic Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Form Version 12 – 9/10/2021 – North Carolina COVID-19 Vaccine Management System*

**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: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

*S*ubscriber 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 |  |  |
| 3rd Dose☐ | **91301-SL** (Moderna SARS-CoV-2 Preservative free vaccine)**0013A** (Administration of 3rd dose of Moderna Vaccine) | 3rd Dose☐ | **91300-SL** (Pfizer SARS-CoV-2 Preservative free vaccine)**0003A** (Administration of 3rd dose of Pfizer Vaccine) |  |  |