Grand Traverse County Health Department
COVID-19 VACCINE ADMINISTRATION RECORD

NAME (Last) (First) (Middle) (Maiden) if applicable

ADDRESS (No. & Street) (City) (State) (Zip)

COUNTY	TELEPHONE		Preferred Method of contact □ Phone □ Mail
DATE OF BIRTH	SEX □ Male □ Female	ETHNICITY □ Arab/Chaldean □ Hispanic/Latino □ Neither	LANGUAGE: □ English □ Other _____
RACE: (Please check one or more) □ Asian □ Black/African American □ Am Indian/Alaskan □Native □Hawaiian/Polynesian □ Unknown □ White □ Multicultural -SELECT TWO ABOVE		ALLERGIES: □ NONE □ If yes, please list: _____	

If under 18 years of age, Emergency Contact:

Last Name:_____ First Name: _____

FOR VACCINE ADMINISTRATOR USE ONLY:

DOSE:	□ 1st Dose □ 2nd Dose
EUA Fact Sheet Date:	
CLINIC:	
SITE:	LD RD
Product Name	
LOT #:	
VAC MFG:	
EXP DATE:	

I certify I have:

- Given a copy of the Emergency Use Authorization Covid-19 Fact Sheet for the vaccination administered today to the client or client's guardian.
- Reviewed the allergies and screening checklist of the client receiving the Covid-19 vaccination.
- Reviewed that the client should wait 15-30 minutes after receiving the vaccine in case of allergic reaction and leaving before that time is against medical advice. Reviewed that if the client suspects an allergic reaction at a later time they should call 911 or go to the nearest hospital.
- Counseled the client/guardian that the person receiving the vaccine today should receive a 2nd dose of the same type of Covid-19 vaccine given today at the appropriate interval.
- Discussed and given a vaccine record card to the client/ guardian.
- Reviewed information on calling the Grand Traverse County Health Department or their healthcare provider to report a concerning side effect or one that does not go away, how to self-report a reaction to the vaccine through VAERS or the vaccine manufacturers website, and gave the client information on enrolling in the V Safe Text based System for the Public.

_____

Signature of Vaccine Administrator and credentials *Date*

Grand Traverse County Health Department
COVID-19 VACCINE BILLING FORM

PATIENT NAME

INSURANCE CARRIER (**Medicare plans see below - we do NOT need your Medicare Advantage Plan info)**

SUBSCRIBER NAME

SUBSCRIBER RELATIONSHIP TO PATIENT	SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SEX
☐ Self ☐ Parent ☐ Partner		☐ Male ☐ Female
INSURANCE CONTRACT NUMBER	INSURANCE GROUP NUMBER (if applicable)	

MEDICARE CLIENTS (**Red, White, & Blue Card Number or Social Security Number)**

I authorize the Grand Traverse County Health Department to release my or the patient's medical information to the insurance company listed above for the purpose of billing insurance for insurance payments. I have been offered a copy of the GTCHD Notice of Privacy Practices.

Signature of Patient (or Parent, Guardian, or Authorized Representative) Date

If you are signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Name of Parent, Guardian, or Authorized Representative (Print) Phone Number Relationship