Entered into MCIR: _____

INGHAM COUNTY HEALTH DEPARTMENT

COVID REGISTRATION FORM - PLEASE PRINT CLEARLY

LAST/FAMILY NAME: _____ **FIRST NAME:** _____ **PREVIOUS NAME:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** ___ **ZIP:** _____

PHONE NUMBER _____ **MALE:** ___ **FEMALE:** ___ **DATE OF BIRTH:** _____

PATIENT IS (circle all that apply): AMERICAN INDIAN ASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN PACIFIC ISLANDER WHITE UNKNOWN/REFUSED	
PATIENT IS: ___ HISPANIC ___ NON-HISPANIC ___ UNKNOWN	
Do you identify as LGBTQ+? **Y / N**	**Are you a refugee or newcomer?** **Y / N**

*****Billing Information***** **Group#**_____**Policy Holders Name:**_____

Insurance Name:_____**Contract #**_____**Insured Persons DOB:** _____

Are you feeling sick today?	**Y / N**	Have you had a COVID-19 positive test in the past 90 days?	**Y / N**
Have you received a dose of COVID-19 vaccine?	**Y / N**	Do you have a bleeding disorder or are you taking a blood thinner?	**Y / N**
- Which vaccine product? (Pfizer or other)		Have you received passive antibody therapy as treatment for COVID-19?	**Y / N**
Have you ever had a serious reaction (e.g. anaphylaxis) to any previous immunization or injectable medication?	**Y / N**	**Are you moderately to severely immunocompromised?**	**Y / N**
- Was the allergic reaction after receiving a COVID-19 vaccine?	**Y / N**	**Are you eligible to receive a Pfizer vaccine booster shot?** • **65+ years old** • **Work or live in high-risk settings** • **18+ years old with underlying medical conditions**	**Y / N**

PLEASE READ THE STATEMENT BELOW:

Receipt of Privacy Notice – I acknowledge that I have been offered a copy of the Ingham County Health Department Notice of Health Information and Privacy Practices: ___ Accept ___ Decline

AUTHORIZATION FOR VACCINE ADMINISTRATION AND BILLING:

I have read, or have had explained to me, the information in the Emergency Authorization Form. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefyits and risks of the specified vaccine. I ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. If I am asking for vaccine to be given to a person for whom I am authorized to make this request, and I attest that I have provided the correct date of birth for that individual. I authorize ICHD to provide emergency medical treatment, if required. We will be billing your insurance for the Administration Fee only – **you will not receive a bill**.

PRINT PATIENT NAME HERE (or parent/guardian name if patient is under 18 years old): _____

SIGN PATIENT NAME HERE (or parent/guardian name if patient is under 18 years old): _____

TODAYS DATE: _____

*************VACCINATOR DOCUMENTATION ON BACK*************

************THE FOLLOWING IS FOR STAFF USE ONLY***********

DATE GIVEN	PROCEDURE CODE	VACCINE TYPE	VACCINE LOT NUMBER		SITE GIVEN	VACCINE ADMINISTRATOR
	91300	**Pfizer Covid-19 Vaccine** **1st : 0001A 2nd : 0002A 3rd : 0003A**				
	91301	**Moderna Covid-19 Vaccine** **1st : 0011A 2nd : 0012A 3rd : 0013A**				
	91303	**J&J Covid-19 Vaccine** **1st : 0031A**				