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.

What is your Vaccine Group?

☐ Group 1	☐ Group 2	☐ Group 3	☐ Group 4	☐ Group 5
Health care workers & Long-Term Care staff and residents	*Anyone 65 years or older, regardless of health status or living situation*	*Frontline essential workers*	*Adults at high risk for exposure and increased risk of severe illness*	*Everyone else who wants a safe and effective COVID-19 vaccination*

Please answer the following questions.	Yes	No	Unsure
1. Are you feeling sick today?			
2. Have you previously received a dose of COVID-19 vaccine before? If yes, which vaccine? ___________ If yes, when was your last dose? _______________			
3. Have you had a **severe** allergic reaction to any of the following?			
• A component of a COVID-19 vaccine			
• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate (found in some vaccines, film coated tablets, and intravenous steroids)			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
5. Have you received any vaccine in the last 14 days?			
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the last 90 days?			

I certify that I am: (a) at least 18 years old (b) the parent/legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, 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: ____ Date: _______________

By signing above, 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 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.

THE VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL.

If you do not have your insurance card with you or 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: ____________________________________

Subscriber Name: ____Subscriber Date of Birth: _____/_____/________

N.C. Driver's License Number (**if no insurance information provided**): ____

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OFFICE USE ONLY

___ Verbal Consent for COVID-19 Vaccine Obtained

Site of Injection (IM): ___ Right Deltoid ___Left Deltoid ___ Other:

*Refer to Triad Care, Inc. COVID fact sheet for eligibility and dosing information.

First Dose	Second Dose	Booster*	Additional Dose* (Immunocompromised Only)
___ Jassen (J&J) 0.5mL	___ Moderna 0.5mL	___ Jassen (J&J) 0.5mL	___ Moderna 0.5mL
___ Moderna 0.5mL	___ Pfizer 0.3mL	___ Moderna 0.25mL	___ Pfizer 0.3mL
___ Pfizer 0.3mL		___ Pfizer 0.3mL	

Administration Date: _________________________ Administration Time: _________________________

Lot #: ___________________________ Expiration: ____

Vaccine Administered By: ___________________________ Signature: ____________________________

Vaccinating Clinic Name: Triad Care, Inc.

Triad Care Notes:

Next Appointment Information (If applicable)

Date: ________________ Time: _______________ AM/ PM