Please bring this completed form to your appointment with photo ID and applicable insurance card(s).

COVID-19 VACCINATION CLINIC
ONSLOW COUNTY HEALTH DEPARTMENT (OCHD)
612 COLLEGE ST., JACKSONVILLE, NC 28540
(910) 347-2154

STAFF USE ONLY:
Appt Date: _____
Appt Time: _____
Clinic:_____

A. QUESTIONNAIRE

1. ☐ Y ☐ N Have you received ANY vaccines in the last 14 days?
2. ☐ Y ☐ N Have you had COVID-19 in the past 30 days?
3. ☐ Y ☐ N Have you received convalescent plasma in the last 90 days?

If YES to 1, 2 or 3 above NOT ELIGIBLE for COVID-19 vaccine today. **STOP**

STAFF NAME VERIFYING ABOVE:

B. PATIENT DEMOGRAPHICS

FULL Name (LASTNAME, FIRSTNAME, MI, GENERATION)	Birth Date (mm/dd/yyyy)	Sex ☐ M ☐ F	SSN (XXX-XX-XXXX)

Race ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Native Hawaiian / Other Pacific Islander

Hispanic Origin ☐ Yes ☐ No

Complete Address (Street, City, State, Zip)	County of Residence

Home Phone	Cell Phone	Work Phone

Email Address:

Best way to contact you? ☐ SMS/Text Message ☐ Email ☐ Both ☐ None

C. INSURANCE INFORMATION *(USED TO FILE ADMINISTRATION OF COVID-19 VACCINE ONLY)*

☐ **UN**INSURED *(Vaccine Administration filed to HRSA; no out-of-pocket expense)*

OCHD USE ONLY
HRSA#:

☐ INSURED *(Vaccine Administration filed to Health Insurance Plan; no out-of-pocket expense)*

Primary Insurance Plan Name	Insurance Plan Policy #	Primary Subscriber info, if different from Section B
		Name: DOB: / /

Patient's Relationship to Primary Subscriber/Policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other Relationship

D. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I am either the patient or the patient's personal representative
- I have received a copy of the "Notice of Privacy Practices" for Onslow County Health Department (OCHD)
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Printed Name of Patient or Guardian	Relationship to Patient
Signature of Patient or Guardian	**Date**

E. HISTORY OF ANAPHYLAXIS

☐ Y ☐ N Do you have a history of **SEVERE (ANAPHYLAXIS)** to a vaccine or other injectable medication?

The following types of allergies and reactions are **NOT** considered **SEVERE** for the purposes of receiving vaccine.

- History of food, pet, insect, venom, environmental, latex, etc., allergies
- History of allergy to oral medications (including the oral equivalent of an injectable medication)
- Non-serious allergy to vaccines of other injectables (e.g., no anaphylaxis)
- Family history of anaphylaxis

STAFF USE ONLY: If YES, wait time = 30 minutes; if No wait time = 15 minutes after vaccination.

Patient's Printed Name (Last, First MI Generation)

Date of Birth:_____

COVID-19 VACCINATION CLINIC

Onslow County Health Department

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 wo wants a safe and effective COVID-19 vaccination.

SECTIONS BELOW COMPLETED BY OCHD STAFF

Verbal Consent Obtained from Patient or Patient's Representative for Vaccine? ☐ Yes

Single Dose Johnson & Johnson			
Vaccine	**Dx**	**Admin Site (circle one)**	**Manufacture & Lot #**
☐ 0031A (B) / 91303* (R) **J&J**	Z23	LD RD LT RT	

I have asked about prior immunizations and reactions. According to informed, no reactions have occurred.	Provider's Signature	Date

**Medicaid plans want to see vaccine w/ SL mod*

Date entered in CVMS / by whom	Date entered in CureMD / by whom

Verbal Consent Obtained from Patient or Patient's Representative for Vaccine? ☐ Yes

1ST Dose COVID-19 VACCINATIONS			
Vaccine	**Dx**	**Admin Site (circle one)**	**Manufacture & Lot #**
☐ 0011A (B) / 91301*(R) **Moderna**	Z23	LD RD LT RT	
☐ 0001A (B) / 91300*(R) **Pfizer**	Z23	LD RD LT RT	

I have asked about prior immunizations and reactions. According to informed, no reactions have occurred.	Provider's Signature	Date

**Medicaid plans want to see vaccine w/ SL mod*

Date entered in CVMS / by whom	Date entered in CureMD / by whom

Verbal Consent Obtained from Patient or Patient's Representative for Vaccine? ☐ Yes

2nd Dose COVID-19 VACCINATIONS			
Vaccine	**Dx**	**Admin Site (circle one)**	**Manufacture & Lot #**
☐ 0012A (B) / 91301* (R) **Moderna**	Z23	LD RD LT RT	
☐ 0002A (B) / 91300 * (R) **Pfizer**	Z23	LD RD LT RT	

I have asked about prior immunizations and reactions. According to informed, no reactions have occurred.	Provider's Signature	Date

**Medicaid plans want to see vaccine w/ SL mod*

Date entered in CVMS / by whom	Date entered in CureMD / by whom