Date:______/______/________

Time: ____________________

CLIENT REGISTRATION FORM
COVID-19 VACCINE

Office Use Only

PT # ______________________

Please complete both sides of this form

LEGAL NAME: (First)__________________________ (Middle)___________ (Last)____

Street Address: ____Apt or Lot#: ______________________

City: ____ State: _________ Zip: _____________ County: _____________________

Date of Birth:______/______/________ Age:_________ Sex: ☐ Female ☐ Male Born in:_________________________________
State / Country

Parent/Guardian Name (client under 18): ____Relationship: _________________________

Home Phone: (______)_________________

Cell Phone: (______)__________________

Message Phone: (_______)__________________

Preferred method of contact/reminder:

☐ Phone ☐ Text ☐ Email ☐ Mail ☐ No Contact

Email: _______________________________________

Please check appropriate box:

Marital Status: ☐ Not Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Not Reporting **Maiden Name:** ________________________

Race: ☐ Black or African American ☐ White ☐ Multiracial ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Unknown
☐ Other _____________________________

Ethnicity: ☐ Hispanic /Latino ☐ Non-Hispanic/Latino ☐ Unknown

Preferred Language: ☐ English ☐ Spanish ☐ Other _______________________________

Can we give your health information to anyone other than you? ☐ Yes ☐ No If yes, who? Name: ___________________________________

Health Insurance:

☐ Medicaid: Medicaid #: ____ ☐ Emergency ☐ Spend down

☐ Medicare: Medicare #: ___________________________ Group #:_______________ ☐ Advantage Plan ☐ Part A ☐ Part B ☐ Part D

☐ Private Insurance: ________________________________ Insurance #:_____________________ Group #:_____________________

☐ Additional/Supplemental Insurance: ____#: ____________________________________

Subscriber Name (if different than client name):_____________________________________ Relationship of Client to Subscriber:________________________

Subscriber Address (If different:)__________________________________City____________________State_________ Subscriber D.O.B: _____/_____/______

Does your health insurance cover the cost of vaccines? ☐ Yes ☐ No

☐ Bill will be Paid by Employer: _________________________________ ___________________________ _______________________
Employer Business Name Contact Name Phone #

Please list ALL income for your family/members in your household, how much and how often you receive this income:
(Optional: to determine sliding fee scale)

Number of family members in household including self: ☐

Source of Gross Income (before taxes) Examples: work, disability, cash assistance, cash from family, etc.	Name of Person Receiving Income	Amount Received	Annually
		$	
		$	
		$	

Office Use Only

Calculated Sliding Fee Scale ___________ % ☐ Declined income - Bill at 100% pay

Berrien County Printing

BERRIEN COUNTY HEALTH DEPARTMENT
better health. stronger communities.

CONSENT & CHARGE SLIP
COVID-19 VACCINATION

TAX ID# 38-6000191

Screening Questions: If a question is not clear, leave it blank and the nurse will explain it *(Client refers to the person receiving the vaccination).*

1	Are you feeling sick today?	☐ YES ☐ NO
2	Have you previously had a COVID-19 Vaccination? If yes, which vaccine did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (J&J) ☐ Other__________________________	☐ YES ☐ NO
3	Have you ever had a serious allergic reaction (e.g. anaphylaxis) to something?	☐ YES ☐ NO
4	Was the severe allergic reaction after receiving a vaccine? If yes: what vaccination:____	☐ YES ☐ NO
5	Do you have a bleeding disorder or are you taking a blood thinner?	☐ YES ☐ NO
6	Have you received another vaccine in the last 14 days?	☐ YES ☐ NO
7	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ YES ☐ NO
8	Are you pregnant or breastfeeding?	☐ YES ☐ NO
9	*If yes to question 8*, have you discussed the COVID-19 vaccination with your medical provider?	☐ YES ☐ NO

My signature below proves:

- I have read or had explained to me the Vaccine's Information Statement (Emergency Use Authorization Vaccine Factsheet) and understand the risks and benefit.
- I consent to the administration of the vaccine's to me or to the person for whom I am authorized to make this request.
- I verify that all of the above information I supplied is correct to the best of my knowledge and have received the HIPAA privacy notice.
- I understand that this administration will be recorded to MCIR and may bill my insurance if applicable.

Client/Guardian Signature: ____ ***Date:*** ________________________

If parent/guardian, my signature above consents to the vaccination of my child by the Berrien County Health Department.

Parent/Guardian Name *(Printed)*:____

Emergency Contact: ____ Phone Number: ______________________________

DO NOT WRITE BELOW THIS LINE

Vaccine	Date Vaccine & FS Given	EUA Public. Date	Vaccine Lot Number	Site Given	Vaccine Dose	Signature of Vaccine Administrator	Eligibility
207 COVID - MODERNA		**10/12/22**					**FP**
219 COVID - PFIZER (6mo-4 yr)		**6/28/22**					**FP**
218 COVID - PFIZER (5-11)		**10/12/22**					**FP**
217 COVID - PFIZER (12+)		**8/31/22**					**FP**
209 COVID - J&J JANSSEN		**5/5/22**					**FP**
211 COVID - NOVAVAX		**10/19/22**					**FP**
229 COVID - MODERNA BIVALENT		**10/12/22**					**FP**
300 COVID PFIZER BIVALENT (12+)		**10/12/22**					
301 COVID PFIZER BIVALENT (5-11)		**10/12/22**					

Initials: ________