Date:______/______/________

Time: ____________________

BERRIEN COUNTY HEALTH DEPARTMENT

better health. stronger communities.

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		1/31/2022					FP
218 COVID - PFIZER (5-11)		1/3/2022					FP
208 COVID - PFIZER (12+)		1/31/2022					FP
209 COVID - J&J JANSSEN		1/31/2022					FP

Initials: ________