McLean County Health Department 200 W. Front St., Bloomington, IL 61701 Phone: 309-888-5450

McLEAN COUNTY HEALTH DEPARTMENT CLIENT REGISTRATION FORM

Today's Date ____/____/_____

Client: Last Name	**First Name**	**MI**	**Birth Date**	**Age**	**Male** **Female**

Address	**City**	**ZIP Code**	**Home Telephone Number**

Email	**Cell Number**

Name of Emergency Contact	**Relationship to Client**	**Telephone Number**

Race: (circle all that apply)	White	Black or African American	Native Hawaiian or Other Pacific Islander	Asian	American Indian or Alaska Native	Other Race:_____ Unknown
Ethnicity	Not Hispanic or Latino		Hispanic or Latino	Unknown		
I verify that I am in the Phase 1a Category:	Clinician/ Healthcare Worker	Clinical Support Non-Clinical Support	**I verify that I am in the Phase 1b or 1b+ Category:**	*Age 65 or over *Essential Worker: 1b_____ *1b plus		

Insurance (circle all that apply)

Aetna Anthem Blue Cross/Blue Shield Cigna Coventry Harmony Health Alliance Health Link HFN, Inc. Humana Illinicare Medicaid Medicare Meridian Meritain Molina Health Care Right Choice United Healthcare Wellpoint

Member Number on Card	**Group Number**	**If you do not plan to utilize insurance coverage for this service, please check here:** ☐

Member Name (if different from client)	**Birth Date**	**Relationship to Client**

Additional Information	**Member's Address (if different from client)**

ASSIGNMENT OF BENEFITS: I understand that the COVID-19 vaccine is free; however, a charge to my insurance may be made for the cost of administering the vaccine. I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to McLean County Health Department for any services furnished to me by the McLean County Health Department. Regulations pertaining to Medicare and Medicaid assignment of benefits apply. I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services. I also hereby acknowledge that I was offered and/or received a copy of the "Notice of Privacy Practices" from the health department dated September 23, 2013. My signature indicates agreement to the above and that all information provided above is true/accurate:

_____ _____

Signature of Client or Legal Representative ***Date***

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Name_____ **Birth date**_____

COVD-19 Questions

TO BE COMPLETED ON THE DAY OF IMMUNIZATION :

Yes	No	
		1. Are you ill today; do you have a fever?
		2. Have you ever received a dose of COVID-19 Vaccine? If so, what product and when? ☐ Pfizer ☐ Moderna ☐ Other: _____ Date of 1st Dose: _____
		3. Have you ever had a serious reaction to a vaccine or other injectable medication? Have you ever had a severe allergic reaction to anything that required treatment with an EpiPen (epinephrine) or a trip to the hospital? If yes, was this reaction to your 1st dose of COVID vaccine? ☐ NO ☐ YES
		4. Do you have a bleeding disorder or are you taking a blood thinner?
		5. Are you breastfeeding, pregnant, or do you plan to get pregnant in the next few months?
		6. Have you received passive antibody therapy as treatment for COVID-19?
		7. Have you had any vaccinations in the past 14 days?

COMMON SIDE EFFECTS: 1) Injection Site Reactions: pain, tenderness, swelling and redness, swelling of lymph nodes in the same arm as the injection; 2) General Side Effects: fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever.
IF YOU EXPERIENCE ANY MORE SERIOUS REACTION THAN DESCRIBED, PLEASE CONTACT YOUR PHYSICIAN.
Your signature below indicates consent to receive the COVID 19 vaccine.

_____ _____
Signature/Authorization of Client/Parent/ or Legal Guardian ***Date***

FOR CLINIC/OFFICE USE

Circle One: **Janssen (Johnson & Johnson)** **Moderna** **Pfizer**

VACCINE ADMINISTERED: **COVID-19**

Circle One: DOSAGE: **0.3 mL (Pfizer)** **or** **0.5 mL (Moderna and Janssen)**

VACCINE LOT NUMBER**:** _____ EXPIRATION DATE: _____

DATE OF ADMINISTRATION: _____ Vaccine Information Statement: EUA ☐

SITE & ROUTE OF INJECTION: **Left** or **Right** **Deltoid IM**

SIGNATURE & TITLE OF VACCINE ADMINISTRATOR: _____

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