BERRIEN COUNTY HEALTH DEPARTMENT
better health. stronger communities.

COVID-19 VACCINATION CONSENT & CHARGE SLIP

TAX ID# 38-6000191

TODAY'S DATE: _____/ _____ / ______ **D.O.B.:** _____/ _____ / ______ **AGE:** _____ **SEX:** ☐ Male ☐ Female ☐ Intersex

LEGAL NAME: (Last) ______________________ (First) ______________________ (Middle) ____________

Maiden/Alias Name: ______________________ Guardian Name: ______________________

Address: ______________________ City: ______________________ State: _________ Zip: ____________

Phone: ______________________ Alternate Phone: ______________________ County: ______________________

RACE *(CHECK ONE)*: ☐ Black or African American ☐ White ☐ Multiracial ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other ____________

ETHNICITY *(CHECK ONE)*: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

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 passive antibody therapy as treatment for COVID-19?	☐ YES ☐ NO
7	Have you received another vaccine in the last 14 days?	☐ YES ☐ NO
8	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
9	Are you pregnant or breastfeeding?	☐ YES ☐ NO
10	*If yes to question 9*, 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		**12/18/20**					**FP**
208 COVID - PFIZER		**12/15/20**					**FP**
209 COVID - J&J JANSSEN		**2/27/21**					**FP**

Initials: ________