



Adult (12+) COVID-19 Vaccination Intake Form

Lead Check _____
Verified in CTWIZ _____
Meditech _____

Patient Name: _____

Gender: _____ Date of Birth: _____ Social Security Number: _____

Address: _____ Age: _____

City: _____ State: _____ Zip code: _____

Email: _____

Phone Number: _____

Responsible Person: _____ Relationship to Patient: _____

Race (circle one): American Indian/ Alaska Native

Hawaiian or other Pacific Islander

Asian

Black or African American

White

Other

Ethnicity (circle one): Hispanic/Latino

Not Hispanic/Latino

Unknown/Not Reported

Additional Helpful Information

Name of Primary Insurance: _____ Insurance ID Number: _____

Subscriber Name: _____

Subscriber DOB: _____ Subscriber Relationship to Patient: _____

OFFICE USE ONLY

VACCINATOR FULL NAME:	
MODERNA FIRST DOSE <input type="checkbox"/>	DATE
MODERNA SECOND DOSE <input type="checkbox"/>	
MODERNA THIRD DOSE <input type="checkbox"/>	
MODERNA BIVALENT VACCINE BOOSTER <input type="checkbox"/>	LOT NUMBER
PFIZER FIRST DOSE <input type="checkbox"/>	
PFIZER SECOND DOSE <input type="checkbox"/>	
PFIZER THIRD DOSE <input type="checkbox"/>	INJECTION SITE
PFIZER BIVALENT VACCINE BOOSTER <input type="checkbox"/>	
NOVAVAX VACCINE 1 ST DOSE <input type="checkbox"/>	
NOVAVAX VACCINE 2 ND DOSE <input type="checkbox"/>	DATA STAFF FULL NAME

SHELTON MOBILE SITE LOCATION: _____



Patient Acknowledgement and Attestation Form for Adult (12+)

COVID-19 Vaccination

I understand and agree to the following as part of my receiving the COVID-19 vaccine from Griffin Hospital:

- There is no co-payment or out-of-pocket expense to me.
- Griffin Hospital has received the vaccine at no cost and will not submit any bills or invoices seeking payment for the cost of the vaccine.
- I agree and consent to receive the COVID-19 vaccine and acknowledge that the risks, benefits, and alternatives have been explained to my satisfaction. I understand the COVID-19 vaccine has the potential side effects. I understand there is a remote risk of more severe or unexpected side effects. I understand that the emergency use of the COVID-19 vaccine has been authorized by the United States Food and Drug Administration (FDA) under an Emergency Use Authorization (EUA).
- I permit Griffin Hospital to obtain payment for administering the vaccine to me. I understand and agree to the following provisions:

Release of confidential information: I understand that my health care information is confidential and is protected from disclosure by law, but that it may be used for treatment, payment for services provided, and healthcare operations.

Release to insurer: I understand that Griffin Hospital and/or any physician entity, or organization providing medical services and may release information to my insurance carrier(s) to substantiate payment for medical care or services, or employers (and/or their insurance carriers) in Workers' Compensation matters. Such persons or entities are permitted to examine and obtain necessary information from my medical records in accordance with application law related to patients' confidential health information and the Medical Records policies of Griffin Hospital.

Assignment of benefits: I assign to Griffin Hospital and/or any physician, entity, or organization providing medical services to me any and all benefits, including payment, to which I may be entitled. Payments include those from any government agency, insurance carrier, or others financially responsible for the medical care rendered to me or my dependent.

Appeal: I agree that Griffin Hospital may appeal any disallowance of payment by my insurance company for medical care rendered.

Provisions specific to Individuals with Medicare Insurance: I certify that the information I have provided for purposes of applying for payment under Title XVIII of the Social Security Act is accurate. I understand that any holder of my medical or other information regarding my treatment may release to the Social Security Administration and/or the Centers for Medicare and Medicaid Services, or its intermediaries or carriers, any necessary information needed in relation to a Medicare claim. In relation to a Medicare claim, I request that payment of authorized benefits be made on my behalf. I assign the Medicare benefits payable for physician services to the physician, entity, or organization furnishing the services or authorize such physician, entity, or organization to submit a claim to Medicare on my behalf.

Attestation: By signing this form I attest that I meet the State of Connecticut vaccination eligibility requirements.

Patient Signature or Responsible Person

Date/Time

Responsible Person's relationship to patient (if applicable)

Prevaccination Checklist for COVID-19 Vaccination



Name _____

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given. It just means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, which vaccine product was administered?			
<input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product			
<input type="checkbox"/> Moderna <input type="checkbox"/> Novavax			
• How many doses of COVID-19 vaccine were administered? _____			
• Did you bring the vaccination record card or other documentation?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? <i>This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant (HCT), or moderate or severe primary immunodeficiency.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the person to be vaccinated ever had an allergic reaction to: <i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>			
• A component of a COVID-19 vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• A previous dose of COVID-19 vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? <i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Check all that apply to the person to be vaccinated:			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?			
<input type="checkbox"/> History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Have a history of thrombosis with thrombocytopenia syndrome (TTS)			
<input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS)			
<input type="checkbox"/> Have a history of COVID-19 disease within the past 3 months?			

Form reviewed by _____

Date _____

Prevaccination Checklist for COVID-19 Vaccination



Yes No Don't know

7. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?

(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)

8. Check all that apply to you:

- Am a female between ages 18 and 49 years old
- Am a male between ages 12 and 29 years old
- Have a history of myocarditis or pericarditis
- Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- Have a bleeding disorder
- Take a blood thinner
- Have a history of heparin-induced thrombocytopenia (HIT)
- Am currently pregnant or breastfeeding
- Have received dermal fillers
- Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____

Date _____