

INSTRUCTIONS (DO NOT PRINT THIS PAGE)

PLEASE READ BEFORE PRINTING THE FORM:

- **If you use this document only to collect data needed in CVMS, please only print the page 1.** Do Not Change Document Spacing on the first page. It has been locked. this document has been created to match the flow of CVMS, simplify data entry and future data recognition capabilities.
- **If you need to collect insurance information and the CDC screening questions, you can also customize and print the page 2.** All tools on that page are customizable for your clinic requirements and needs. **Do not print the second page if unnecessary.**

ADDITIONAL INSTRUCTIONS TO ASSIST RECIPIENTS FILLING THE FORM

IF EMPLOYED, IN WHAT INDUSTRY DO YOU WORK? (Page 1)

Categories of essential worker industries available in CVMS:

- Commercial Facilities (e.g. retail workers, hotel workers)
- Commercial Facilities for Essential Goods
- Critical Manufacturing
- Defense Industrial Base
- Education
- Energy
- Finance
- Food and Agriculture
- Governmental and Community Services
- Health Care
- Hygiene Products and Services
- Industries involving Chemicals or Hazardous Materials
- IT & Communication
- Public Health
- Public Safety
- Public Works and Infrastructure Support Services
- Residential Facilities, Housing, and Real Estate
- Transportation
- Water and Wastewater
- Other

HOW MANY CONDITIONS DO YOU HAVE THAT PUT YOU AT RISK FOR DEVELOPING SEVERE ILLNESS FROM COVID-19? (Page 1)

List of known conditions (<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>)

Adults of any age with the following conditions **are at increased risk** of severe illness from the virus that causes COVID-19:

- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Down Syndrome
- Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index [BMI] of 30 kg/m² or higher but < 40 kg/m²)
- Severe Obesity (BMI ≥ 40 kg/m²)
- Pregnancy
- Sickle cell disease
- Smoking
- Type 2 diabetes mellitus

Adults of any age with the following conditions **might be at an increased risk** for severe illness from the virus that causes COVID-19:

- Asthma (moderate-to-severe)
- Cerebrovascular disease (affects blood vessels and blood supply to the brain)
- Cystic fibrosis
- Hypertension or high blood pressure
- Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines
- Neurologic conditions, such as dementia
- Liver disease
- Overweight (BMI > 25 kg/m², but < 30 kg/m²)
- Pulmonary fibrosis (having damaged or scarred lung tissues)
- Thalassemia (a type of blood disorder)
- Type 1 diabetes mellitus

VERBAL CONSENT OBTAINED (Page 1)

Verbal Consent: The patient or legal guardian has been provided the benefits and potential adverse reactions and provides consent to receive the vaccine.

Administering healthcare providers must provide an approved Emergency Use Authorization (EUA) fact sheet as required to each vaccine recipient, the adult caregiver accompanying the recipient, or other legal representative.

PREVACCINATION CHECKLIST FOR COVID-19 VACCINES (Page 2)

You can include the CDC pre-vaccination screening questions or a local document on the customizable second page. Please download the latest version here: <https://www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf>

Recipient Registration and COVID-19 Vaccine Administration Form

Recipient Full Name: _____ Date of Birth ____/____/____
Recipient Email Address: _____ No email
Have you already registered in the CVMS Recipient Portal? Yes No
Home Phone Number: _____ Mobile Phone Number: _____
Address: _____ City: _____
Zip Code: _____ County: _____ State: _____
What is the name of the organization you work for (or reside in)? _____ Not employed
If employed, in what industry do you work? (healthcare, food and agriculture, manufacturing, education, etc.)

Best way to contact you: SMS/Text Message Email Both None
Recipient Race: American Indian/Alaska Native Asian Black/African American
 Native Hawaiian or Other Pacific Islander White Other
Recipient Ethnicity: Hispanic or Latino Not Hispanic or Latino
Recipient Gender: Male Female Other I do not want to specify
Do you identify as any of the following?
 Frontline essential worker (in person at work) Resident of a congregate/group setting
 Other essential worker (non-frontline) Resident of a long-term care facility
 Patient-facing healthcare worker or long-term care facility worker Student
 School and child care frontline essential worker None of the above
How many conditions do you have that put you at risk for developing severe illness from COVID-19?
 None 1 2 or more

I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an 'applicable Provider'), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

Recipient signature _____

OFFICE USE ONLY

Verbal Consent for COVID-19 Vaccine Obtained

Site of Injection: Right Deltoid, IM Left Deltoid, IM Other _____

Dose: First Dose Second Dose

Administration Date: ____/____/____

Administration Time: _____

COVID-19 Vaccine Manufacturer: _____

Lot #: _____ Exp: ____/____/____

Manufacturer sticker (optional)

Vaccine administered by (Clinician Name) _____ Signature _____

Vaccinating Clinic Name _____

THE VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL.

If you have your insurance card with you today or if you are not insured, you do not need to fill out the insurance information.
INSURANCE INFORMATION/AUTHORIZATION TO BILL (copy of front and back of insurance card preferred for verification)

Insurance Name: _____ Member ID: _____

Group Number: _____ Phone Number: _____

Medical Claims Address: _____

Subscriber Name: _____ Subscriber Date of Birth: ____/____/____

Subscriber Address: _____

I authorize payment from 3rd Party Payer (Insurance) and Medicare/Medicaid be made on my behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature above will serve as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to the licensed healthcare provider administering the vaccine for services rendered.

PREVACCINATION CHECKLIST FOR COVID-19 VACCINES

PLACEHOLDER

OFFICE USE ONLY (VACCINE BILLING INFORMATION)

1 st Dose <input type="checkbox"/>	91301-SL (Moderna SARS-CoV-2 Preservative free vaccine) 0011A (Administration of 1 st dose of Moderna Vaccine) Dx z23	1 st Dose <input type="checkbox"/>	91300-SL (Pfizer SARS-CoV-2 Preservative free vaccine) 0001A (Administration of 1 st dose of Pfizer Vaccine) Dx z23	1 st Dose <input type="checkbox"/>	<i>For future use</i>
2 nd Dose <input type="checkbox"/>	91301-SL (Moderna SARS-CoV-2 Preservative free vaccine) 0012A (Administration of 2 nd dose of Moderna Vaccine) Dx z23	2 nd Dose <input type="checkbox"/>	91300-SL (Pfizer SARS-CoV-2 Preservative free vaccine) 0002A (Administration of 2 nd dose of Pfizer Vaccine) Dx z23		