

**HAVE YOU HAD YOUR COVID-19  
VACCINE?**

**DO YOU NEED A SECOND DOSE?**

**HAS YOUR DOCTOR RECOMMENDED A 3<sup>RD</sup>  
DOSE (FOR THE MODERATELY-SEVERELY  
IMMUNOCOMPROMISED)?**

**READY FOR YOUR BOOSTER DOSE?**

**JOIN US AT THE HOWELL TOWNSHIP  
SENIOR CENTER**

**251 PREVENTORIUM RD.**

**\*\*\*\* MAKE SURE TO BRING YOUR ORIGINAL  
VACCINE CARD, WEAR YOUR MASK, AND FILL  
OUT THE ATTACHED FORM**

**TRANSPORTATION IS AVAILABLE. YOU MUST  
CALL THE HOWELL SENIOR CENTER AT 732-938-  
4500 EXT. 2550**

**CLINIC IS FOR AGES 5 YEARS OLD AND UP**

**DATES:**

**JULY 27  
AUGUST 31  
SEPTEMBER 28**

**TIME: 4PM-7PM**

**No  
appointment  
is necessary**

**FREE!!!**

**There is no charge  
for the vaccine or  
administration**

**Pfizer, Moderna and  
Janssen (Johnson &  
Johnson) vaccines  
will be available**

**Sponsored by:  
Howell Township  
Senior Center and  
Monmouth County  
Health Department**

Date: \_\_\_\_\_

MONMOUTH COUNTY HEALTH DEPARTMENT (MCHD)

NJIS# \_\_\_\_\_

Report #: \_\_\_\_\_

50 East Main St  
Freehold, NJ 07728 TEL: 732-431-7456

Location: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Adult

EUA Date: \_\_\_\_\_

**Section 1: (PLEASE PRINT)**

EUA Date Given: \_\_\_\_\_

1st Dose	_____
Mfr./Lot	_____
2nd Dose	_____
Mfr./Lot	_____
Admin. by MCHD?	Y      N

LAST NAME	(FIRST)	(M.I.)	DATE OF BIRTH	
			/	/
			(month)	(day) (year)
MAILING ADDRESS	CITY	STATE	ZIP	GENDER <small>(circle one)</small>
				M    F    Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Race:	Ethnicity	PHONE		
	Hispanic: <input type="checkbox"/> Non-Hispanic: <input type="checkbox"/>			

**Section 2: Insurance**

PRIMARY INSURANCE: _____	SECONDARY INSURANCE: _____
INSURANCE ID: _____	INSURANCE ID: _____
<input type="checkbox"/> No Insurance	

**Section 3: Consent for Vaccination**

I authorize the submission of a claim to Medicare, Medicaid or any other payer for the services provided to me by MCHD now, in the past, or in the future, until I revoke this authorization in writing by certified mail. I understand that an insurance claim will not be submitted if I elected to opt out of insurance billing. I agree to immediately remit to MCHD any payment that I receive directly from insurance or any source for the services provided to me and I assign all rights to such payments to MCHD. I authorize MCHD to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical insurance, billing or other relevant information about me to release such information to MCHD and its billing agents, the Centers for Medicare and Medicaid Services and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by MCHD, now, in the past or in the future. I also authorize MCHD to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information. I/We request payment of any medical insurance benefits to go directly to MCHD. I/We permit a copy of this authorization to be used in place of the original. A copy of this form is as valid as the original. I have received the Emergency Use Authorization for the current Covid-19 vaccine and understand the risks and benefits. Immunizations provided thru this Federal and State Program will be registered in NJIIS (NJ Immunization Information System).

I give consent to the *Monmouth County Health Department* to administer the Covid-19 vaccine to me or the person named above for whom I am authorized to give consent, as his/her parent/legal guardian.

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(Print) \_\_\_\_\_ Relationship: \_\_\_\_\_

**FOR ADMINISTRATIVE USE ONLY**

Vaccine	Date Administered:			Staff Signature	Vaccine Manufacturer Lot Number & Exp
	1 <sup>st</sup> Dose	2 <sup>nd</sup> Dose	3 <sup>rd</sup> Dose		
COVID-19	IM R    L Arm    Leg	IM R    L Arm    Leg	IM R    L Arm    Leg		

# Prevaccination Checklist for COVID-19 Vaccines



## For vaccine recipients:

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

Name \_\_\_\_\_

Age \_\_\_\_\_

	Yes	No	Don't know
<b>1.</b> Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2.</b> Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>If yes, which vaccine product did you receive?                              <input type="checkbox"/> Pfizer-BioNTech    <input type="checkbox"/> Moderna    <input type="checkbox"/> Janssen (Johnson &amp; Johnson)    <input type="checkbox"/> Another Product _____                         </li> <li>Have you received a complete COVID-19 vaccine series (i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])?</li> <li>Did you bring your vaccination record card or other documentation?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3.</b> Have you 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>			
<ul style="list-style-type: none"> <li>A component of a COVID-19 vaccine, including either of the following:                             <ul style="list-style-type: none"> <li>Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures</li> <li>Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids</li> </ul> </li> <li>A previous dose of COVID-19 vaccine</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4.</b> Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<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>			
<b>5.</b> Check all that apply to you:			
<input type="checkbox"/> Am a female between ages 18 and 49 years old			
<input type="checkbox"/> Am a male between ages 12 and 29 years old			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies			
<input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
<input type="checkbox"/> Have a bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies			
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Am currently pregnant or breastfeeding			
<input type="checkbox"/> Have received dermal fillers			
<input type="checkbox"/> History of Guillain-Barré Syndrome (GBS)			

Form reviewed by \_\_\_\_\_

Date \_\_\_\_\_