Madison County Health Department

◊ 493 Medical Park Drive ◊ Marshall, NC 28753 ◊
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www.madisoncountypublichealthnow.com

Screening Questionnaire for COVID Vaccination

Parent or Guardian must complete the form in its entirety before an immunization will be received.

PATIENT INFORMATION		
Last:	**First:** **MI:**	
DOB:	**SS#:**	
Mailing Address:	**City, State, Zip:**	
Home Phone:	**Cell Phone:**	
Race: Caucasian African American Other	**Male Female**	**Hispanic Origin? Y or N**
Member of a tribal nation? Y or N		

INSURANCE INFORMATION	
Primary Insurance:	**Secondary Insurance:**
Address:	**Address:**
Policy #:	**Policy #:**
Group #:	**Group #:**
Subscriber Name:	**Subscriber Name:**
Subscriber DOB: **Subscriber SS#:**	**Subscriber DOB:** **Subscriber SS#:**

SCREENING

For adult patients as well as parents of children to be vaccinated: The following questions will help us to determine if there is any reason we should not give you or your child the COVID vaccine today. If you answer "yes" to a question it does not necessarily mean you (or your child) should not receive the vaccine, it means additional questions must be asked.

Screening Questions	Y	N
Is the person to be vaccinated sick today?		
Have you had any vaccine in the last 2 weeks?		
Do you take blood thinner medication that requires you to have blood drawn on a regular basis?		
Is the person to be vaccinated currently pregnant?		
Do you have any acute/chronic medical conditions that affects your immune system?		
Has the person to be vaccinated ever had Guillian-Barre?		
Does the person to be vaccinated today have any allergies? If so to what?		
Are you an essential frontline worker? If so where?		

Statement of permission, assignment, and consent for treatment: I voluntarily give my permission to receive the COVID vaccine. I understand that payment for this service may be made in accordance with the provisions of Title XVIII and/or Title XIX of the Social Security Act; and/or private insurance or other third-party payer. I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on my behalf, and I authorize payment to provider for such claim, and give permission for the above information to be released to my primary physician, as well as consent for treatment.

Signature: _____ **Date:** _____

Email Address: _____

FOR PROVIDER USE ONLY:	
COVID Vaccine Administered by:	**Inj Site: RD or LD**
MFG/LOT #:	

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:	
By signing below, I am acknowledging that: I am either the patient or the patient's personal representative I have received a copy of the "Notice of Privacy Practices" for Madison County Health Department I understand that I may contact MCHD if I have questions about the content of the notice.	
Signature: (of patient or parent/legal guardian/legally responsible person)	**Date:**
Relationship to Patient	

TO BE COMPLETED BY STAFF	
Part 1. Complete if signature requested but not obtained:	
Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:	
Patient/personal representative refused to sign form	
Other	
Part 2. Complete if patient/personal representative unavailable to sign form on the date of service:	
Form mailed/sent to patient/personal representative on:	
	Date:
Part 3. Complete if either Part 1 or Part 2 are completed:	
Signature of staff member:	**Date:**

Circle any health condition listed that you have:

Asthma **Immunocompromised from solid organ transplant** **Overweight** **Pregnancy**

Cancer **immunocompromised state (weak immune system)** **Pulmonary fibrosis** **COPD**

Cystic Fibrosis **High Blood Pressure** **Diabetes** **Liver Disease** **Stroke** **Obesity** **Smoker**

Sickle Cell Disease **Blood Disorder** **Neurological Conditions** **Chronic Kidney Disease**