SALT LAKE COUNTY
HEALTH DEPARTMENT

COVID Vaccine Clinic Encounter Form

Primary Insurance: SelectHealth United Health Care PEHP EMI Health Aetna Medicare Medicaid Blue Cross Blue Shield
*(NOT **Focal Point** or **IND & Fam** Plans)*

Patient First Name ______ Patient Last Name ______ Patient Middle Name/Initial ______

Patient Date of Birth ______ Age ______ Sex ______ Race ______ Hispanic or Latino? Y N

Mailing Address ______ City ______ State ______ ZIP ______

Phone; may we text this number? Y N ______ Cell Carrier ______ Email Address ______

Relationship to person receiving treatment: Self Parent/Guardian Other: ______

(If not self): Parent's Name ______ Name of Insured ______ Insured Date of Birth ______ Policy Number ______ Group Number ______

1. Are you feeling well today? **Y N**
2. Allergies to foods or medications? **Y N** (If yes, type of allergy: ______)
3. Any problems with previous vaccines or fainting? **Y N**
4. Have you had any vaccine in the last 14 days? **Y N**
5. Are you currently in isolation or quarantine for COVID infection or exposure? **Y N**
   If yes, do you live in a group living facility of any kind? **Y N**
6. If you have had passive antibody therapy to treat COVID-19, has 90 days passed since completion? **Y N N/A**
7. If you are female and over 9 years old, could you be pregnant? **Y N N/A**
   If yes, we recommend discussing receiving the vaccine from your OBGYN provider.

STOP! HEALTH DEPARTMENT USE ONLY BELOW

Administration Pfizer	Administration Moderna	Administration AstraZeneca	Administration Janssen
0001A – First Dose	0011A – First Dose	0021A – First Dose	0031A – First Dose
0002A – Second Dose	0012A – Second Dose	0022A – Second Dose	

CPT	ICD10	Service	Lot #	Site	Dose	Route
91300	Z23	COVID-19 Pfizer			0.3cc	IM
91301	Z23	COVID-19 Moderna			0.5cc	IM
91302	Z23	COVID-19 AstraZeneca			0.5cc	IM
91303	Z23	COVID-19 Janssen			0.5cc	IM

Provider Name: ______

Provider Signature: ______ ***Date***: ___/___/___

Office Use Only

Client PID Number: ______ **Date:** ___/___/___

Registered: Employee Name ______ **Close Out: Employee Signature**

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Conditions of Treatment

Please read and initial each item below:

_____ **Consent for Treatment**
I have received a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement(s) about the vaccine(s) I have requested or have been recommended to me, their risks, and about the disease(s) that the vaccine(s) protect against. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated in the Vaccine Information Statement(s) stated above be given to me or to the person for whom I am authorized to make this request. I certify that these statements are true and accurate.

_____ **Privacy Rights**
I have been provided and have had the opportunity to read Salt Lake County Health Department's Notice of Privacy Practices. Furthermore, any questions I had regarding the policy have been explained to me by the Health Department staff. In addition, I understand that I may request a copy of these practices in a reasonable alternative format. I agree that this information may be shared with health care providers, health care personnel, public health personnel and other health care professionals who have a legitimate need to access the immunization information to: verify immunization status; audits; conduct public health studies; and assist a patient or to protect the health of individuals closely associated with the patient. I understand that I have the right to revoke this authorization at any time by notifying the Salt Lake County Health Department in writing. This release of information will be effective until canceled in writing. I understand that once my data is shared with another individual or agency, it may lose the protections provided by the HIPAA Privacy Rule, and may be re-disclosed by that recipient.

Indicate relationship to the person receiving services:

☐ Self ☐ Parent ☐ Sibling (over 18) ☐ Grandparent
☐ Guardian ☐ Other: ________________________________

If under 18 years of age:

I am a:

☐ Pregnant Minor ☐ Married Minor ☐ Homeless Teen

By signing, you indicate that you have read, understand, and agree to these terms; that you have received a copy of this document; and that you are the patient, guarantor, the patient's legal representative, or legally authorized to sign this agreement and accept these terms.

Patient Name (please print): ____

Your Name (please print): ____

Signature: ______________________________________ Date: ___________