The Long Beach Island Health Department
2119 Long Beach Blvd., 1st Floor
Ship Bottom, NJ 08008
609-492-1212

COVID Vaccination Registration Form

Date of Birth _____/_____/_____ **Gender:** _____ Female _____Male

First Name: _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone Number:** _____

	Yes	No
1. Are you feeling sick today and/or do you have a fever of ≥ 100 degrees Fahrenheit?		
2. Have you tested positive for COVID-19? If yes when was your test date? _____		
3. Have you received passive antibody therapy as treatment for COVID-19?		
4. Have you ever had a severe allergic reaction?		
5. Do you have any bleeding disorders or on blood thinners?		
6. Are you considered an immunocompromised patient?		
7. Have you received another vaccine in the last 14 days?		
8. Have you ever received a dose of COVID-19 Vaccine? If yes, which vaccine product? ☐Pfizer ☐Moderna ☐ Another Product:_____		

I have read, or have had explained to me, the CDC Emergency Use Authorization Form about the Moderna Vaccine. I understand that this vaccine may cause symptoms in some people but will not actually cause the Covid Virus. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of Covid vaccine and request that the vaccine be given to me or for whom I am authorized to make this request. I have answered all questions truthfully and accurately. I request that payment of authorized Insurance benefits be made to me or on my behalf to the Long Beach Island Health Department for any services furnished to me by the LBIHD. I authorize any holder of medical information about me to release to the insurance carrier of record and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____

Insurance Information *Please document as it appears on Insurance Card

Provider or Carrier Name: _____

Provider or Member ID# _____

Group ID#_____

Please provide your **Medicare number** if applicable: _____

No out-of-pocket expense for vaccine, Insurance information is requested to help offset the cost of providing this service to you as the resident.

Do Not Write in The Space Below

☐ **Moderna Vaccine 0.5ml I.M.** **Lot #** **Exp. Date**

Left Deltoid **Right Deltoid** **Dose #1**_____ **Dose #2**_____

Signature of Nurse: _____ **Date:**_____

Revised 1/4/2020