COVID-19 VACCINATION ADMINISTRATION FORM

Name:					**ID/Social Security Number:**	
Address:						
	Street	City	State	Zip	County	
Birthdate: / /					**Phone Number:**	
	Month Day Year					
RACE: check one or more	☐ American Indian or Alaska Native	☐ Asian	☐ Black or African American	☐ Native Hawaiian or other Pacific Islander	☐ White	☐ Other
Ethnicity:	Hispanic or Latino			**Sex:**	☐ Female	☐ Male
	☐ Yes	☐ No				
Do you have MEDICAID?	☐ Yes	☐ No	**If Yes, Medicaid number:**			
Do you have MEDICARE?	☐ Yes	☐ No	**If Yes, Medicare number:**			
Do you have health insurance?	☐ Yes	☐ No	**If Yes, company name:**			
Policy #:		**Subscriber Name:**			**Group #:**	

The COVID-19 vaccine is free. An administration fee may be billed to your insurance company or a government fund for the uninsured but will not result in any cost to the vaccine recipient.

I authorize the billing of the administration fee to my insurance provider if applicable.

Signature of person to receive vaccine or legal guardian/representative	Date

For Facility Use Only:

COVID-19 Vaccine Manufacturer	ADMINISTRATION		
Johnson & Johnson/Janssen NDC# 59676-0580-15 Manufacture Date: 06/14/2021		First Dose	
		Lot #: **1822811**	Exp. Date: **03/20/2022**
		Site (IM):	Administered by:
		Date:	Time:
		Second Dose	
		Lot #:	Exp. Date:
		Site (IM):	Administered by:
		Date:	Time: