COVID-19 VACCINATION ADMINISTRATION RECORD

Sangamon County Department of Public Health
2833 South Grand Avenue East, Springfield, IL 62703
(217) 535-3100
Tax ID #37-6002039 NPI #1164448262

Please **PRINT** information about the person to receive the vaccine:

NAME: ______________________________ ______________________________ _______
Last **First** **M.I.**

BIRTHDATE: ________________ **AGE:**______ **GENDER:**__________

RACE: _________ **NON-HISPANIC:** **HISPANIC:**

HOME ADDRESS:____**IL**__________
Street **City** **Zip Code**

DAYTIME TELEPHONE: _________________ **EMERGENCY NUMBER:**___________________

**I understand this agency is HIPAA compliant and has HIPAA information available to me upon request.*
**I have been provided with the opportunity to take a paper copy of the Vaccine Information Statement (VIS), or I may download the VIS onto my mobile device from www.cdc/vaccines/pubs/vis/vis-downloads.htm to view and I give consent to the Sangamon County Department of Public Health to administer the vaccine.*
If applicable, I give permission to the Sangamon County Department of Public Health to bill **Medicare/Medicaid/Insurance for the administration of the COVID-19 immunization.*

SIGNATURE X_______________________________________ **TODAY'S DATE** _____________
Patient or Parent/Guardian if under 18 years of age

An administration fee will be billed to your insurance, if you have insurance. If your insurance denies the fee that we bill, you will not be billed for it.

Medicaid: Please provide 9 digit Number:_________________________________

Medicare: Please provide Medicare Number:_______________________________

Insurance:

Aetna	**Coventry**	**Molina**
Aetna Better Health Care	**Health Alliance**	**United Healthcare**
Blue Cross/Blue Shield MCO	**HFS (SKILO)**	**Other**______________
Blue Cross/Blue Shield PPO	**Illinicare**	**None**
Cigna	**Meridian**	

ID/Subscriber Number: ______________________________ **Group Number:**________________________

Site of Vaccination: **Left Deltoid** _____ **Right Deltoid** _____

Manufacturer: **Pfizer** **Lot#**__________________
Moderna **Lot#**__________________
Other **Lot#**__________________

First Dose
Second Dose

Provider Signature:____ **Date:**_________________

PLEASE PRINT AND BRING THIS FORM TO APPOINTMENT