Clay County Health Department
Covid – 19 Vaccination Administration Record

Information for person receiving vaccine – Please Print in Ink

Last Name: _____ **First Name:** _____ **Middle Initial**_____

Date of Birth _____ **Age:** _____ **Male:** ☐ **Female:** ☐ **Phone #:** _____

Address: _____ **City:** _____ **Zip:** _____

Race: _____ **Ethnicity: Hispanic** ☐ **Not Hispanic** ☐

(Circle Response)

1. Is the person to be vaccinated today feeling well? ☐ **Yes** **or** ☐ **No**
2. Have you experienced any severe allergic reactions to any medications? ☐ **Yes** **or** ☐ **No**
3. Do you have an immunocompromising medical condition? ☐ **Yes** **or** ☐ **No**

I have been given the opportunity to read the Clay County Health Department's Notice of Privacy Practices and to have any questions answered. I understand the risks and benefits of the COVID – 19 vaccine. I consent the vaccine be given to myself or child named above for whom I am authorized to make this request. I give permission to have the immunization data stored in the State of Illinois Electronic Medical Record System (I-Care).

_____ _____

Patient or Parent/Guardian Signature *Date*

For Clinic/Office Use Only:

Insurance: (Aetna / BCBS / Cigna / Healthlink / Health Alliance / Humana / TriCare / Trustmark / UHC)

Insurance ID# _____ Insurance Group#: _____

Medicare Part B# _____ Medicaid (RIN) #: _____

Payment: Cash/Check #_____ or Credit Card VFC: _____ PVT: _____

Injection Date: _____ Vaccine: **Comirnaty** ☐ **Spike Vax** ☐ Lot #: _____

Expiration Date: _____ Site: ☐ **Left** ☐ **Right** ☐ **Deltoid** ☐ **Thigh**

Nurse Signature: _____

2026-2027