



2026-27 FLU/COVID VACCINATION FORM

Name: _____ Date of birth: _____ Race: _____ Sex: _____
Phone #: _____ Soc. Sec. #: _____ Hispanic: ☐ Yes ☐ No
Address: _____
Mother's maiden name (last, first) _____ ☐ Insured ☐ Noninsured
☐ Medicare #: _____ ☐ Medicaid #: _____
Pvt insurance name _____ Policy # _____ Group/ID# _____
Claim mailing address _____
Name of card holder if not same as patient _____
Date of birth of cardholder _____ Relationship to patient _____
Company bill _____

Initials **STATEMENT OF UNDERSTANDING:** I have read and understand the information provided to me about receiving vaccines and I have had the opportunity to ask questions.

Initials I give my voluntary consent for Albemarle Regional Health Services to use and disclose health/medical information for purposes of treatment, payment, and health care operations. I request that payment of benefits be made to Albemarle Regional Health Services with the understanding that any unpaid balance from co-pays, deductibles, and/or non-covered charges will be my responsibility. I understand that the health/medical information used and disclosed may include information about communicable diseases (such as HIV). I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I understand that this consent is valid until I revoke it and that if I want to revoke this consent, I must do so in writing.

Initials I hereby acknowledge that I may request a copy of the "Notice of Privacy Practices" for Albemarle Regional Health Services and understand that I may contact the person named therein if I have questions about the content of the Notice.

Signature of patient, parent, legal guardian, or other legally responsible person (when required)

Date

Signature of Witness

Date

Providers use only:

Allergies to any vaccines _____

Influenza Vaccine Mfr./Lot# _____ Exp Date: _____ Site: ☐ Right/ ☐ Left ☐ Deltoid/ ☐ Thigh Date: _____ Administered by: _____

☐ This patient verbally attests to having an underlying condition, which puts her/him at higher risk for severe outcomes from COVID-19.

Date: _____ Provider Initials: _____

COVID Vaccine Mfr./Lot# _____ Exp Date: _____ Site: ☐ Right/ ☐ Left ☐ Deltoid/ ☐ Thigh Date: _____ Administered by: _____

Other Vaccine Mfr./Lot# _____ Exp Date: _____ Site: ☐ Right/ ☐ Left ☐ Deltoid/ ☐ Thigh Date: _____ Administered by: _____

CPT CODE	NDC #	TRADE NAME	STATE	PRIVATE	DOSE	AGE RANGE
90660	66019-0113-10	Flumist	☐	☐	0.2 mL Intranasal	2 years – 49 years
90656	49281-0426-50	Fluzone	☐	☐	0.5mL (single-dose syringe)	6 months & older
90656	19515-0822-52	Flulaval	☐	☐	0.5mL (single-dose syringe)	6 months & older
90661	70461-0656-03	Flucelvax	☐	☐	0.5mL (single-dose syringe)	6 months & older
90653	70461-0026-03	FLUAD	☐	☐	0.5 mL (single-dose syringe)	65 years & older
91321	80777-0115-80	Spikevax	☐	☐	0.25mL (single-dose prefilled syringe)	6 months- 11 years
91322	80777-0114-96	Spikevax	☐	☐	0.5mL (single-dose prefilled syringe)	12 years & older
91323	80777-0401-60	mNEXSPIKE	☐	☐	0.2 mL (single-dose prefilled syringe)	12 years & older

90471	Injection – x's 1 unit	G0008	FLU Injection for Medicare
90472	Injection – 2 or more UNITS	G0009	Pneumonia injection for Medicare
90480	COVID Admin Fee		