Putnam County Health Department
COVID-19 Vaccine Administration Record

Patient Name ______________________________________ **Date of Birth** _________________

Address ___________________________________ **City** ______________ **ST** ____ **ZIP** _______

Phone #__________________ **Age** ____ **Male**____ **Female** ____ **Physician** ________________

Please answer the following questions about the person to receive the vaccine:	**No**	**Yes**
• Are you sick today?		
• Have any allergies to glycerol, tromethamine, acetic acid, sodium acetate, or sucrose, latex?		
• In the past two weeks, have you tested positive for COVID-19 or are currently being monitored for COVID-19?		
• In the past two weeks, have you had contact with anyone who tested positive for COVID-19?		
• In the past 90 days, have you receive passive antibody therapy (convalescent plasma or monoclonal antibodies) as part of COVID-19 treatment?		
• Have you ever had a serious reaction after receiving a vaccination?		
• Do you have a weakened immune system or in the past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments?		
• Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, or any other immune system problems?		
• Do you have any chronic/long term health problems?		
• Have you had a seizure or other nervous system problem?		
• For women, are you pregnant or is there a chance you could become pregnant during the next month?		
• Have you received any vaccines in the past 14 days?		

Vaccine Consent

Consent related to privacy notice: I have had a chance to review the Privacy Notice as part of this registration process. I understand the Terms of the Privacy Notice may change and I may get these changed notices by contacting PCHD by phone or in writing.

I have received a copy of the Fact Sheet for Recipients and Caregivers. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I give permission for my name and birthdate to be released to state and federal Government for required reporting purposes.

____ ____________________

Signature of Patient / Parent / or Legal Guardian **Date**

For office use only

Manufacturer	Vaccine Lot #	Date Administered	Admin. Site	Dosage	Nurse Signature
Moderna	039K20A			0.5 mL	

Please complete the following information if you have any type of insurance coverage:

(Skip this section if we are not billing an insurance plan.)

Medicaid Billing ID Number ______________________________ **Group Number** _______________
Name of Medicaid Managed Care Company ____

Medicare Billing ID# ______________________________ **Group Number** (if any)_______________
Name of Medicare Provider/Company ____

Primary Insurance Coverage
Name of Insurance Company ____
Name of person on card ____
Address of Insurance Company____
ID # on insurance card __________________________Group # on insurance card_________________
Birthdate of card holder ________________
Address of card holder____

Secondary Insurance Coverage
Name of Insurance Company ____
Name of person on card ____
Address of Insurance Company____
ID # on insurance card ______________________________Group # on insurance card______________
Birthdate of card holder ______________
Address of card holder____

Select all that apply:

_____ I request PCHD to bill my **Insurance or Medical Coverage Plan** (provide copy of the card)

_____ I will pay cash/check at the time of service if applicable

Consent for assignment of benefits: I give permission for my insurance to be billed and acknowledge I am financially responsible for the patient responsibility according to my insurance guidelines. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be stated to be my responsibility by the insurance agency, as required by any contract with my insurance agency and state regulation. I also understand that my contract with my insurance agency may or may not cover some services. It is my responsibility to get information from my health insurance agency about services that are not covered. If I get care outside of my health insurance plan, I am aware that I may be responsible for all charges that may be due. I authorize PCHD to give information to the identified insurance carrier(s) for any and all payment activities.

By signing this consent, I authorize the use and/or disclosure of my health information for treatment, payment or health care operations.

Patient/Parent/Legal Guardian Signature __________________________________ **Date** ___________________

Occupational Data Checklist for COVID-19 Vaccine Recipients: Please **check only one** box below as the primary reason you are receiving the COVID-19 Vaccine.

□	Assisted Living Facility – Resident	□	Congregate Care Facility – Resident
□	Assisted Living Facility – Staff	□	Congregate Care Facility – Staff
□	Skilled Nursing Facility – Resident	□	Hospital Worker – Clinical Staff
□	Skilled Nursing Facility – Staff	□	Hospital Worker – Administrative Staff
□	State of Ohio Dept. of Dev. Disabilities – Resident	□	Hospital Worker – Ancillary Staff
□	State of Ohio Dept. of Dev. Disabilities – Staff	□	Non-Hospital healthcare worker – Administrative Staff
□	State of Ohio Veterans Home – Resident	□	Non-Hospital healthcare worker – Ancillary Staff
□	State of Ohio Veterans Home – Staff	□	Non-Hospital healthcare worker – Clinical Staff
□	State of Ohio Mental Health & Addiction Services – Resident	□	Emergency Medical Services (EMT / Paramedic)
□	State of Ohio Mental Health & Addiction Services – Staff	□	State of Ohio Dept. of Rehabilitation & Correction – LTC Staff
□	State of Ohio Dept. of Rehabilitation & Correction – LTC Residents		