Putnam County Health Department
COVID-19 Vaccine Administration Record

Patient Name _____ **Date of Birth** _____

Address _____ **City** _____ **ST** ____ **ZIP** _____

Phone #_____ **Age** ____ **Sex** □ **Female** □ **Male**

Race □ **White** □ **Black** □ **Asian** □ **Other** _____

Ethnicity □ **Hispanic/Latino** □ **Not Hispanic/Latino**

Please answer the following questions about the person to receive the vaccine:	**No**	**Yes**
• Are you sick today?		
• Have you ever had a severe allergic reaction to a vaccine or any injection in the past?		
• Have any allergies to potassium chloride, monobasic potassium, phosphate, sodium chloride, dibasic sodium phosphate dihydrate, glycerol, tromethamine, acetic acid, sodium acetate, sucrose, or latex?		
• Have you had any type of vaccine in the last two weeks?		
• Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?		
• In the past two weeks, have you been identified as either a probable or confirmed case of COVID-19?		
• In the past two weeks, have you been identified as a close contact with anyone who tested positive for COVID-19?		
• In the past 90 days, have you received antibody therapy (convalescent plasma or monoclonal antibodies) for COVID-19?		
• Do you have any serious health conditions (often called co-morbidities)?		
• Do you have a weakened immune system (i.e., from HIV or cancer) or are you on immunosuppressive drugs?		
• Do you have a bleeding disorder or are you taking a blood thinner?		
• For women, are you pregnant or breastfeeding or is there a chance you could become pregnant during the next month?		
Is this your first or second dose of COVID-19? □ First □ Second First dose manufacturer _____ First dose date _____		

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to learn about the benefits and risks (VIS) of the COVID-19 vaccine. Please visit our website (posted at the clinic) to read our Privacy Policy (PP). By signing below, you agree that 1) you reviewed both the VIS and PP, 2) you understand the benefits and risks of the vaccine and you are asking that the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby consent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record and all information on this form to your state's Immunization Program and the CDC, and 5) we can release this record to your doctor, school, or employer if requested. If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient and the patient on this form may receive vaccine with or without you, as the parent or guardian, present at the time of vaccination. After receiving your vaccine we recommend you wait at least 15 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time. Please be aware that staff may be taking pictures for social media and clinic improvement purposes. If you do not want your picture to be taken please let us know at the clinic.

_____ _____

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

For office use only

Manufacturer	**Vaccine Lot #**	**Date Administered**	**Admin. Site**	**Dosage**	**Nurse Signature**
Moderna				0.5 mL	
Pfizer				0.3mL	

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_____

What group are you in: Please **check only one** box below.

□	Assisted Living Facility – Staff	□	Individuals age 65 to 69 years of age
□	Congregate Care Facility – Resident	□	Individuals w/congenital disorders or early onset conditions
□	Congregate Care Facility – Staff	□	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 MHAS Resident	□	Non-Hospital healthcare worker – Ancillary Staff
□	State of Ohio MHAS Staff	□	Non-Hospital healthcare worker – Clinical Staff
□	Individuals over 80 years of age	□	Emergency Medical Services (EMT / Paramedic)
□	Individuals age 75 to 79 years of age	□	Individuals working in K-12 schools
□	Individuals age 70 to 74 years of age	□	Individuals without IDD and congenital disorders or early onset conditions