Putnam County Health Department

COVID-19 Vaccine Administration Record

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST \_\_\_\_ ZIP \_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_ Sex □ Female Race □ White

□ Male □ Black

Ethnicity □ Hispanic/Latino □ Asian

□ Not Hispanic/Latino □ Other \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| ***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** **0.3 mL**  **0.5 mL** | **Nurse Signature** |

(Skip this section if we are not billing an insurance plan or if you are providing a copy of your insurance card)

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.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **PHASE 1A** |  | **PHASE 1B** |
| □ | Assisted Living Facility – Staff or Resident (circle) | □ | Over 80 years of age |
| □ | Skilled Nursing Facility – Staff or Resident (circle) | □ | Age 75 to 79 years of age |
| □ | State of Ohio Dept. of Dev. Disabilities – Staff or Resident (circle) | □ | Age 70 to 74 years of age |
| □ | State of Ohio Veterans Home – Staff or Resident (circle) | □ | Age 65 to 69 years of age |
| □ | State of Ohio Mental Health and Addiction Services (MHAS) - Staff or Resident (circle) | □ | Congenital disorders or early onset conditions with IDD |
| □ | State of Ohio Dept. of Rehabilitation & Correction – LTC – Staff or Resident (circle | □ | Congenital disorders or early in life conditions that carried into adulthood without IDD |
| □ | Congregate Care Facility – Staff or Resident (circle) | □ | Individuals working in K-12 schools |
| □ | Hospital Worker – Clinical Staff | □ | **PHASE 1C** |
| □ | Hospital Worker – Administrative Staff |  | Diabetes Type 1 |
| □ | Hospital Worker – Ancillary Staff | □ | Pregnant |
| □ | Non-Hospital healthcare worker – Administrative Staff | □ | Bone Marrow Transplant recipient |
| □ | Non-Hospital healthcare worker – Ancillary Staff | □ | ALS |
| □ | Non-Hospital healthcare worker – Clinical Staff | □ | Childcare services worker |
| □ | Emergency Medical Services (EMT / Paramedic) | □ | Funeral services worker |
|  | **PHASE 1C** |  | **PHASE 1D** |
| □ | Diabetes Type 1 | □ | Type 2 diabetes |
| □ | Pregnant | □ | End-stage renal disease |
| □ | Bone marrow transplant recipient |  | **PHASE 1E** |
| □ | ALS | □ | Cancer, CKD, COPD, heart disease, obesity (circle) |
| □ | Childcare services worker |  | **PHASE 2** |
| □ | Funeral services worker | □ | Individuals age 60 to 64 years of age |
| □ | Law enforcement, corrections, firefighter | □ | Individuals age 50 to 59 years of age |
|  |  | □ | Individuals age 40 to 49 years of age |
|  |  | □ | Individuals age 16 to 39 years of age |