

ID _____

COVID-19 Vaccine Registration Form

01/11/2021

FIRST NAME		MIDDLE INITIAL	LAST NAME			CVX CODE	CPT CODE
DATE OF BIRTH / /		AGE	17 OR UNDER? <input type="checkbox"/> Yes <input type="checkbox"/> No	MISSED APPT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	REFUSAL <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	RACE <input type="checkbox"/> Alaskan Native (5) <input type="checkbox"/> American Indian (5) <input type="checkbox"/> Asian (4) <input type="checkbox"/> Black (2) <input type="checkbox"/> Native Hawaiian (7) <input type="checkbox"/> Pacific Islander (7) <input type="checkbox"/> White (1) <input type="checkbox"/> Other (6) <input type="checkbox"/> Unknown (9)	ETHNICITY <input type="checkbox"/> Hispanic/Latino (1) <input type="checkbox"/> Not Hispanic/Latino (2) <input type="checkbox"/> Unknown (3) SEX <input type="checkbox"/> Female (F) <input type="checkbox"/> Male (M) <input type="checkbox"/> Other (O) <input type="checkbox"/> Unknown (U)
PHONE NUMBER	OK TO TEXT? Yes No	EMAIL			OK TO EMAIL? Yes No		
STREET ADDRESS							
CITY		STATE	ZIP	COUNTY OF RESIDENCE			

PATIENT QUESTIONS – ANSWER THE DAY OF VACCINATION

Have you had any type of vaccine in the last two weeks?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you ever had a severe allergic reaction to a vaccine or any injection in the past?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you <u>ever</u> tested positive for COVID-19 or had a doctor tell you that you had COVID-19?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have any serious health conditions (often called co-morbidities)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have a weakened immune system (i.e., from HIV or cancer) or are you on immunosuppressive drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are you pregnant or breastfeeding?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you feel sick today?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Is this your first or second dose <u>in the last month</u> ?	<input type="checkbox"/> First dose	<input type="checkbox"/> Second dose

What group are you in? (select only one)

- First dose manufacturer _____
First dose date _____
- | | | |
|--|--|---|
| <input type="checkbox"/> Assisted Living Facility Resident (TVP1) | <input type="checkbox"/> Congregate Care Facility Resident (TVP13) | <input type="checkbox"/> Individuals age 65 to 69 years of age (TVP65) |
| <input type="checkbox"/> Assisted Living Facility Staff (TVP2) | <input type="checkbox"/> Congregate Care Facility Staff (TVP14) | <input type="checkbox"/> Individuals w/congenital disorders or early-onset conditions (TVP22) |
| <input type="checkbox"/> Skilled Nursing Facility Resident (TVP3) | <input type="checkbox"/> Hospital worker Clinical Staff (TVP15) | <input type="checkbox"/> Individuals working in K-12 schools (TVP23) |
| <input type="checkbox"/> Skilled Nursing Facility Staff (TVP4) | <input type="checkbox"/> Hospital worker Administrative Staff (TVP16) | |
| <input type="checkbox"/> State of Ohio DODD Resident (TVP5) | <input type="checkbox"/> Hospital worker Ancillary Staff (TVP17) | |
| <input type="checkbox"/> State of Ohio DODD Staff (TVP6) | <input type="checkbox"/> Non-Hospital healthcare worker Clinical Staff (TVP18) | |
| <input type="checkbox"/> State of Ohio Veterans Home Resident (TVP7) | <input type="checkbox"/> Non-Hospital healthcare worker Administrative Staff (TVP19) | |
| <input type="checkbox"/> State of Ohio Veterans Home Staff (TVP8) | <input type="checkbox"/> Non-Hospital healthcare worker Ancillary Staff (TVP20) | |
| <input type="checkbox"/> State of Ohio MHAS Resident (TVP9) | <input type="checkbox"/> Emergency Medical Services EMTs/Paramedics (TVP21) | |
| <input type="checkbox"/> State of Ohio MHAS Staff (TVP10) | <input type="checkbox"/> Individuals over 80 years of age (TVP80) | |
| <input type="checkbox"/> State of Ohio DRC LTC Resident (TVP11) | <input type="checkbox"/> Individuals age 75 to 79 years of age (TVP75) | |
| <input type="checkbox"/> State of Ohio DRC LTC Staff (TVP12) | <input type="checkbox"/> Individuals age 70 to 74 years of age (TVP70) | |

Please visit the CDC website [cdc.gov/coronavirus/2019-ncov/vaccines/index.html](https://www.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 have 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 CONSENT/SIGNATURE (or parent/guardian if the patient is age 17 or under)	DATE OF CONSENT / /
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OFFICE USE ONLY

VACCINE NAME COVID-19	LOT NUMBER	EXPIRATION DATE	DOSE SIZE <input checked="" type="checkbox"/> Full (1.0) <input type="checkbox"/> Half (0.5)	MANUFACTURER <input type="checkbox"/> Moderna (MOD) <input type="checkbox"/> Johnson & Johnson (JNJ) <input type="checkbox"/> Pfizer (PFR) <input type="checkbox"/> Merck <input type="checkbox"/> AstraZeneca (ASZ) <input type="checkbox"/> Novavax <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> Sanofi
ROUTE OF ADMIN <input checked="" type="checkbox"/> IM <input type="checkbox"/> TD <input type="checkbox"/> IV <input type="checkbox"/> NS <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> O <input type="checkbox"/> Oth	SITE OF INJECTION <input type="checkbox"/> RA <input type="checkbox"/> RD <input type="checkbox"/> RT <input type="checkbox"/> Other <input type="checkbox"/> LA <input type="checkbox"/> LD <input type="checkbox"/> LT _____	DOSE IN SERIES <input type="checkbox"/> First <input type="checkbox"/> Second	SERIES COMPLETE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
VACCINATOR	NOTES	DATE OF VACCINATION / /		
CLINIC LOCATION	CLINIC TYPE	CLINIC ADDRESS	STATE VACCINE SYSTEM DATA ENTRY <input type="checkbox"/> By clinic/agency GIVING vaccine (N) <input type="checkbox"/> By clinic/agency NOT giving vaccine (Y)	