

ID _____

COVID Vaccine Registration Form

20211021.1

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		
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 or had a doctor tell you that you had COVID?					<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you been identified as either a probable or confirmed case of COVID in the <u>last two weeks</u> ?					<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID 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 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
Are you immunocompromised, have a weakened immune system, or on immunosuppressive drugs?					<input type="checkbox"/> No	<input type="checkbox"/> Yes
How many doses of COVID vaccine (any type) have you <u>already received</u> ?					<input type="checkbox"/> 0	<input type="checkbox"/> 1 <input type="checkbox"/> 2
Manufacturer and date of your FIRST dose of COVID vaccine:					<input type="checkbox"/> N/A	<input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson ____/____/____
Manufacturer and date of your SECOND dose of COVID vaccine:					<input type="checkbox"/> N/A	<input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson ____/____/____
If you are getting a <u>booster</u> dose, what vaccine would you prefer?					<input type="checkbox"/> N/A	<input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson
Y O U R G R O U P	<input type="checkbox"/> Age 5 to 11 years of age (TPVALL)	<input type="checkbox"/> Chronic Kidney Disease (TPV35)	<input type="checkbox"/> Non-Hospital healthcare worker Clinical Staff (TPV18)			
	<input type="checkbox"/> Age 12 to 18 years of age (TPVALL)	<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (TPV36)	<input type="checkbox"/> Non-Hospital healthcare worker Admin Staff (TPV19)			
<input type="checkbox"/> Age 19 to 39 years of age (TPVALL)	<input type="checkbox"/> Congenital or early onset conditions <u>with</u> IDD (TPV22)	<input type="checkbox"/> Non-Hospital healthcare worker Ancillary Staff (TPV20)				
<input type="checkbox"/> Age 40 to 49 years of age (TPV40)	<input type="checkbox"/> Congenital or early onset conditions <u>without</u> IDD (TPV24)	<input type="checkbox"/> Obesity (TPV38)				
<input type="checkbox"/> Age 50 to 59 years of age (TPV50)	<input type="checkbox"/> Congregate Care Facility Resident (TPV13)	<input type="checkbox"/> Pregnant (TPV26)				
<input type="checkbox"/> Age 60 to 64 years of age (TPV60)	<input type="checkbox"/> Congregate Care Facility Staff (TPV14)	<input type="checkbox"/> School staff in K-12 schools (TPV23)				
<input type="checkbox"/> Age 65 to 69 years of age (TPV65)	<input type="checkbox"/> Diabetes Type 1 (TPV25)	<input type="checkbox"/> Skilled Nursing Facility Resident (TPV3)				
<input type="checkbox"/> Age 70 to 74 years of age (TPV70)	<input type="checkbox"/> Diabetes Type 2 (TPV32)	<input type="checkbox"/> Skilled Nursing Facility Staff (TPV4)				
<input type="checkbox"/> Age 75 to 79 years of age (TPV75)	<input type="checkbox"/> Emergency Medical Services EMTs/Paramedics (TPV21)	<input type="checkbox"/> State of Ohio DODD Resident (TPV5)				
<input type="checkbox"/> Age 80 years of age & older (TPV80)	<input type="checkbox"/> End Stage Renal Disease (TPV33)	<input type="checkbox"/> State of Ohio DODD Staff (TPV6)				
<input type="checkbox"/> ALS (TPV28)	<input type="checkbox"/> Funeral Services Worker (TPV30)	<input type="checkbox"/> State of Ohio DRC LTC Resident (TPV11)				
<input type="checkbox"/> Assisted Living Facility Resident (TPV1)	<input type="checkbox"/> Heart Disease (TPV37)	<input type="checkbox"/> State of Ohio DRC LTC Staff (TPV12)				
<input type="checkbox"/> Assisted Living Facility Staff (TPV2)	<input type="checkbox"/> Hospital worker Clinical Staff (TPV15)	<input type="checkbox"/> State of Ohio MHAS Resident (TPV9)				
<input type="checkbox"/> Bone Marrow Transplant Recipient (TPV27)	<input type="checkbox"/> Hospital worker Administrative Staff (TPV16)	<input type="checkbox"/> State of Ohio MHAS Staff (TPV10)				
<input type="checkbox"/> Cancer (TPV34)	<input type="checkbox"/> Hospital worker Ancillary Staff (TPV17)	<input type="checkbox"/> State of Ohio Veterans Home Resident (TPV7)				
<input type="checkbox"/> Childcare Services Worker (TPV29)	<input type="checkbox"/> Law Enforcement/Corrections/Firefighter (TPV31)	<input type="checkbox"/> State of Ohio Veterans Home Staff (TPV8)				
Please visit the CDC website cdc.gov/vaccines/covid-19/eua or ask one of our staff to learn about the benefits and risks (Vaccine Information Sheet, or VIS) of the COVID vaccine. Please visit our website to read our Privacy Policy (PP) or ask one of our staff for a copy. 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, 5) we can provide this vaccination record to your doctor, school, or employer if they request it, 6) you are truthfully claiming to be a part of the target group/population you identified on the registration, 7) if you are registering for a second, third, or booster dose, you are accurately reporting the dates and manufacturers of previous doses, and 8) if you are registering for a booster dose, you are attesting to be in one of the approved groups to receive a booster. 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 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 patient is age 17 or under)					DATE OF CONSENT / /	
Whoa there. That's far enough. We'll take it from here.						
PATIENT SICK TODAY? <input type="checkbox"/> Yes <input type="checkbox"/> No	VACCINE NAME COVID-19	MANUFACTURER <input type="checkbox"/> Pfizer 12+ (PFR) <input type="checkbox"/> Moderna (MOD) <input type="checkbox"/> Pfizer 5-11 (PFR 5-11) <input type="checkbox"/> Johnson & Johnson (JSN)		LOT #	EXPIRATION DATE	
DOSE SIZE <input type="checkbox"/> Full (1.0) <input type="checkbox"/> Half (0.5)	DOSE IN SERIES <input type="checkbox"/> First <input type="checkbox"/> Third <input type="checkbox"/> Other <input type="checkbox"/> Second <input type="checkbox"/> Booster		SERIES COMPLETE <input type="checkbox"/> Yes <input type="checkbox"/> No	BOOSTER MANUFACTURER SAME AS PRIMARY SERIES <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No		
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"/> Other	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		VACCINATOR	DATE OF VACCINATION / /		
CLINIC LOCATION	CLINIC TYPE	CLINIC ADDRESS		STATE VACCINE SYSTEM DATA ENTRY <input checked="" type="checkbox"/> By clinic/agency GIVING vaccine (N) <input type="checkbox"/> By clinic/agency NOT giving vaccine (Y)		