ID _____

COVID Vaccine Registration Form

20211021.1

FIRST NAME	MIDDLE INITIAL	LAST NAME	CVX CODE	CPT CODE

DATE OF BIRTH	AGE	17 OR UNDER?	MISSED APPT	REFUSAL
/ /		☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No

RACE
☐ Alaskan Native (5)
☐ American Indian (5)
☐ Asian (4)
☐ Black (2)
☐ Native Hawaiian (7)
☐ Pacific Islander (7)
☐ White (1)
☐ Other (6)
☐ Unknown (9)

ETHNICITY
☐ Hispanic/Latino (1)
☐ Not Hispanic/Latino (2)
☐ Unknown (3)

SEX
☐ Female (F)
☐ Male (M)
☐ Other (O)
☐ 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?	☐ No	☐ Yes
Have you <u>ever</u> tested positive for COVID or had a doctor tell you that you had COVID?	☐ No	☐ Yes
Have you been identified as either a probable or confirmed case of COVID in the <u>last two weeks</u>?	☐ No	☐ Yes
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID in the last 3 months?	☐ No	☐ Yes
Do you have any serious health conditions (often called co-morbidities)?	☐ No	☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No	☐ Yes
Are you pregnant or breastfeeding?	☐ No	☐ Yes
Are you immunocompromised, have a weakened immune system, or on immunosuppressive drugs?	☐ No	☐ Yes
How many doses of COVID vaccine (any type) have you <u>already received</u>?	☐ 0	☐ 1 ☐ 2

Manufacturer and date of your FIRST dose of COVID vaccine: ☐ N/A ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ____/____/____

Manufacturer and date of your SECOND dose of COVID vaccine: ☐ N/A ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ____/____/____

If you are getting a <u>booster</u> dose, what vaccine would you prefer? ☐ N/A ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson

YOUR GROUP

☐ Age 5 to 11 years of age (TPVALL)	☐ Chronic Kidney Disease (TPV35)	☐ Non-Hospital healthcare worker Clinical Staff (TPV18)
☐ Age 12 to 18 years of age (TPVALL)	☐ Chronic Obstructive Pulmonary Disease (TPV36)	☐ Non-Hospital healthcare worker Admin Staff (TPV19)
☐ Age 19 to 39 years of age (TPVALL)	☐ Congenital or early onset conditions <u>with</u> IDD (TPV22)	☐ Non-Hospital healthcare worker Ancillary Staff (TPV20)
☐ Age 40 to 49 years of age (TPV40)	☐ Congenital or early onset conditions <u>without</u> IDD (TPV24)	☐ Obesity (TPV38)
☐ Age 50 to 59 years of age (TPV50)	☐ Congregate Care Facility Resident (TPV13)	☐ Pregnant (TPV26)
☐ Age 60 to 64 years of age (TPV60)	☐ Congregate Care Facility Staff (TPV14)	☐ School staff in K-12 schools (TPV23)
☐ Age 65 to 69 years of age (TPV65)	☐ Diabetes Type 1 (TPV25)	☐ Skilled Nursing Facility Resident (TPV3)
☐ Age 70 to 74 years of age (TPV70)	☐ Diabetes Type 2 (TPV32)	☐ Skilled Nursing Facility Staff (TPV4)
☐ Age 75 to 79 years of age (TPV75)	☐ Emergency Medical Services EMTs/Paramedics (TPV21)	☐ State of Ohio DODD Resident (TPV5)
☐ Age 80 years of age & older (TPV80)	☐ End Stage Renal Disease (TPV33)	☐ State of Ohio DODD Staff (TPV6)
☐ ALS (TPV28)	☐ Funeral Services Worker (TPV30)	☐ State of Ohio DRC LTC Resident (TPV11)
☐ Assisted Living Facility Resident (TPV1)	☐ Heart Disease (TPV37)	☐ State of Ohio DRC LTC Staff (TPV12)
☐ Assisted Living Facility Staff (TPV2)	☐ Hospital worker Clinical Staff (TPV15)	☐ State of Ohio MHAS Resident (TPV9)
☐ Bone Marrow Transplant Recipient (TPV27)	☐ Hospital worker Administrative Staff (TPV16)	☐ State of Ohio MHAS Staff (TPV10)
☐ Cancer (TPV34)	☐ Hospital worker Ancillary Staff (TPV17)	☐ State of Ohio Veterans Home Resident (TPV7)
☐ Childcare Services Worker (TPV29)	☐ Law Enforcement/Corrections/Firefighter (TPV31)	☐ 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?	VACCINE NAME	MANUFACTURER	LOT #	EXPIRATION DATE
☐ Yes ☐ No	COVID-19	☐ Pfizer **12+** (PFR) ☐ Moderna (MOD) ☐ Pfizer **5-11** (PFR 5-11) ☐ Johnson & Johnson (JSN)		

DOSE SIZE	DOSE IN SERIES	SERIES COMPLETE	BOOSTER MANUFACTURER SAME AS PRIMARY SERIES
☒ Full (1.0) ☐ Half (0.5)	☐ First ☐ Second ☐ Third ☐ Booster ☐ Other _____	☐ Yes ☐ No	☐ Yes ☐ N/A ☐ No

ROUTE OF ADMIN	SITE OF INJECTION	VACCINATOR	DATE OF VACCINATION
☒ IM ☐ TD ☐ IV ☐ NS ☐ SC ☐ ID ☐ O ☐ Other	☐ RA ☐ RD ☐ RT ☐ Other ☐ LA ☐ LD ☐ LT		/ /

CLINIC LOCATION	CLINIC TYPE	CLINIC ADDRESS	STATE VACCINE SYSTEM DATA ENTRY
			☒ By clinic/agency GIVING vaccine (N) ☐ By clinic/agency NOT giving vaccine (Y)