Clinton County Health District

Pamela Walker-Bauer, MPH, RS, Health Commissioner
Steven J Englender, MD, MPH, Medical Advisor
111 S Nelson Ave Suite 1 Wilmington, Ohio 45177 Phone: (937)382-3829
Fax: (937)382-7027 Email : info@clincohd.com

COVID- 19 VACCINE ADMINISTRATION RECORD

DATE OF SERVICE	FIRST NAME	MIDDLE INITIAL	LAST NAME

DATE OF BIRTH	AGE	PRIMARY INSURANCE & MEMBER ID NUMBER	SECONDARY INSURANCE & MEMBER ID NUMBER

STREET ADDRESS CITY, STATE ZIP PHONE NUMBER	**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)

PATIENT QUESTIONS – ANSWER THE DAY OF VACCINATION

Question		
Do you feel sick today?	☐ No	☐ Yes
Have you ever received a dose of COVID-19 vaccine? If so, which brand? ☐ Pfizer- BioNTech ☐ Novavax How Many Doses of COVID-19 previously administered? _____ ☐ Moderna ☐ Another Product: ☐ Janssen (Johnson&Johnson) Date of Last Dose: ____________	☐ No	☐ Yes
Do you have a health condition or undergoing treatment that makes them moderately or severely immunocompromised?	☐ No	☐ Yes
Have you ever received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐ No	☐ Yes
Have you ever had an allergic reaction to a component of the COVID-19 vaccine or a previous dose? *(This would include a severe allergic reaction*	☐ No	☐ Yes
Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	☐ No	☐ Yes
Do any of the following apply to you? If so, Check all that apply: ☐ Have a history of myocarditis or pericarditis ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)? ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT) ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS) ☐ Have a history of Guillain-Barré Syndrome (GBS) ☐ Have a history of COVID-19 disease within the past 3 months?	☐ No	☐ Yes

Today I am here to:

- ☐ Begin or complete initial series of J&J, Moderna, or Pfizer Covid vaccine.
- ☐ Receive a BIVALENT booster dose, 2 months following a completed primary series of Moderna, Pfizer, J&J, or Novavax
- ☐ Receive an additional primary shot because I am moderately or severely immunocompromised and have consulted my medical provider that encouraged me to receive an additional dose.
- ☐ Receive a booster dose, for 11 and younger 5 months following a completed primary series of Pfizer

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. By signing below, you agree that 1) 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 theclinic.

PATIENT CONSENT/SIGNATURE (or parent/guardian if patient is age 17 or under) **X**	**DATE OF CONSENT** / /

OFFICE USE ONLY

VACCINE NAME **COVID-19**	**LOT NUMBER**	**EUA PROVIDED** ☒ Yes	**V SAFE PROVIDED** ☒ Yes	**MANUFACTURER & DOSAGE** ☐ Moderna- 0.5cc BIVALENT Booster Dose (18+ year) ☐ Pfizer- 0.3cc BIVALENT Booster Dose (12+ year) ☐ Moderna - 0.5cc (red, 12yrs +) ☐ Moderna- 0.25cc PEDS (magenta, 6mo thru 5 yrs) ☐ Moderna- 0.5cc PEDS (purple, 6yr thru 11yrs) ☐ Pfizer- 0.3cc (gray, 12yrs & up) ☐ Pfizer- 0.2cc PEDS (orange, 5-11 yrs) ☐ Pfizer- 0.2cc PEDS (maroon, 6mo thru 4yrs)
VACCINATOR INITIALS	**ROUTE OF ADMIN** ☒ IM ☐ TD ☐ IV ☐ NS ☐ SC ☐ ID ☐ O ☐ Other	**SITE OF INJECTION** ☐ RD ☐ LD ☐ RT ☐ LT	**NOTES**	

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Revised 9.7.22