ID_______ COVID-19 Vaccine Consent Form

1A.20201221noins

FIRST NAME	MIDDLE INITIAL	LAST NAME	TODAY'S DATE
			/ /

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

PHONE NUMBER OK TO TEXT? Yes No	EMAIL OK TO EMAIL? Yes No

STREET ADDRESS

RACE
- ☐ American Indian (5)
- ☐ Alaskan Native (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)

CITY	STATE	ZIP	COUNTY OF RESIDENCE

PATIENT QUESTIONS – ANSWER THE DAY OF VACCINATION

Question		
Are you sick today?	☐ No	☐ Yes
Have you ever had a severe allergic reaction to something in the past?	☐ No	☐ Yes
• Was the reaction from a previous COVID vaccine?	☐ No	☐ Yes
• Was the reaction from another vaccine or another injectable medication?	☐ No	☐ Yes
Have you ever tested positive for COVID-19 or has a doctor told you that you had COVID-19?	☐ No	☐ Yes
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum)?	☐ No	☐ Yes
Have you had any type of vaccine in the last two weeks?	☐ No	☐ Yes
Do you have a weakened immune system or take immunosuppressive drugs or therapies?	☐ No	☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No	☐ Yes
Are you pregnant or breastfeeding?	☐ No	☐ Yes
Is this your first or second dose in the last month?	☐ First dose	☐ Second dose

First dose manufacturer ______________________

What group are you in? (select only one)

- ☐ Assisted Living Facility Resident (TVP1)
- ☐ Assisted Living Facility Staff (TVP2)
- ☐ Skilled Nursing Facility Resident (TVP3)
- ☐ Skilled Nursing Facility Staff (TVP4)
- ☐ State of Ohio DODD Resident (TVP5)
- ☐ State of Ohio DODD Staff (TVP6)
- ☐ State of Ohio Veterans Home Resident (TVP7)
- ☐ State of Ohio Veterans Home Staff (TVP8)
- ☐ State of Ohio MHAS Resident (TVP9)
- ☐ State of Ohio MHAS Staff (TVP10)
- ☐ State of Ohio DRC LTC Resident (TVP11)
- ☐ State of Ohio DRC LTC Staff (TVP12)
- ☐ Congregate Care Facility Resident (TVP13)
- ☐ Congregate Care Facility Staff (TVP14)
- ☐ Hospital worker Clinical Staff (TVP15)
- ☐ Hospital worker Administrative Staff (TVP16)
- ☐ Hospital worker Ancillary Staff (TVP17)
- ☐ Non-Hospital healthcare worker Clinical Staff (TVP18)
- ☐ Non-Hospital healthcare worker Administrative Staff TVP19)
- ☐ Non-Hospital healthcare worker Ancillary Staff (TVP20)
- ☐ Emergency Medical Services EMTs/Paramedics (TVP21)
- ☐ Individuals age 80 years of age + (TVP80)
- ☐ Individuals age 75-79 years of age (TVP75)
- ☐ Individuals age 70-74 years of age (TVP70)
- ☐ Individuals age 65-69 years of age (TVP65)
- ☐ Individuals age 60-64 years of age (TPV60)
- ☐ Individuals age 50-59 years of age (TPV50)
- ☐ Individuals age 40-49 years of age (TPV40)
- ☐ Individuals age 16 to 39 years of age (TPVALL)
- ☐ Individuals with Congenital Disorders or Early Onset Conditions with IDD (TVP22)
- ☐ Individuals Working in K-12 Schools (TVP23)
- ☐ Individuals with Congenital Disorders or Early in Life Conditions that Carried into Adulthood without IDD (TVP24)

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to read the Vaccine Information Sheet (VIS-EUA) for the COVID-19 vaccine. Please visit our website (www.warrenchd.com) to read the Privacy Policy (PP). By signing below, you agree that 1) you were given the opportunity to review both the VIS (EUA) 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 to your state's Immunization Program and the CDC, and 5) we can release your immunization record to your doctor or school 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, you must wait 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 SIGNATURE (or parent/guardian if patient is age 17 or under)	DATE
	/ /

Whoa there. That's far enough. We'll take it from here.

VACCINE NAME	LOT NUMBER	EXPIRATION DATE	DOSE SIZE
COVID-19			☐ 0.3 ml ☐ 0.5 ml

ROUTE OF ADMIN	SITE OF INJECTION	DOSE IN SERIES	SERIES COMPLETE?
☒ IM ☐ TD ☐ IV ☐ NS ☐ SC ☐ ID ☐ O ☐ Oth	☐ Left Arm ☐ Left Thigh ☐ Right Arm ☐ Right Thigh	☐ First ☐ Second	☐ Yes ☐ No

MANUFACTURER
- ☐ Pfizer
- ☐ Johnson & Johnson
- ☐ Moderna
- ☐ Merck
- ☐ AstraZeneca
- ☐ Novavax
- ☐ GlaxoSmithKline
- ☐ Sanofi

VACCINATOR	NOTES	CVX CODE	CPT CODE
		207	

CLINIC LOCATION	CLINIC TYPE	CLINIC ADDRESS	STATE VACCINE SYSTEM DATA ENTRY
WCHD		416 S. East St, Lebanon 45036	☒ By clinic/agency GIVING vaccine (N) ☐ By clinic/agency NOT giving vaccine (Y)

ID__________COVID-19 Vaccine Consent Form-Qualifying Conditions 1A.20201221noins

☐ Diabetes Type 1 (TPV25) ☐ Diabetes Type 2 (TPV32) ☐ End Stage Renal Disease (TPV33) ☐ Pregnant (TPV26) ☐ Bone Marrow Transplant Recipient (TPV27) ☐ ALS (TPV28) ☐ Cancer (TPV34) ☐ Chronic Kidney Disease (TPV35) ☐ Chronic Obstructive Pulmonary Disease (TPV36)	☐ Heart Disease (TPV37) ☐ Obesity (TPV38) ☐ Childcare Services Worker (TPV29) ☐ Funeral Services Worker (TPV30) ☐ Law Enforcement, Corrections, Firefighter (TPV31)	**Phase**

Phase 1B Medical Conditions

Ohioans born with or who have early childhood conditions that are carried into adulthood, which put them at a higher risk for adverse outcomes due to COVID-19, are eligible for vaccination under Ohio's Vaccination Program Phase 1B.

Vaccinations for this group of Ohioans will take place in two phases. During the first phase, which began Jan. 25, eligibility was for individuals who have a developmental or intellectual disability AND one of the conditions listed below. During the second phase, beginning Feb. 15, eligibility will expand to any individuals with one of the conditions below:

• Sickle cell anemia

• Down syndrome

• Cystic fibrosis

• Muscular dystrophy

• Cerebral palsy

• Spina bifida

• People born with severe heart defects, requiring regular specialized medical care

• People with severe type 1 diabetes, who have been hospitalized for this in the past year

• Phenylketonuria (PKU), Tay-Sachs, and other rare, inherited metabolic disorders

• Epilepsy with continuing seizures, hydrocephaly, microcephaly, and other severe neurological disorders

• Turner syndrome, fragile X syndrome, Prader-Willi syndrome, and other severe genetic disorders

• Severe lung disease, including people with severe asthma, who have been hospitalized for this in the past year

• Alpha and beta thalassemia

• Solid organ transplant candidates and recipients

By signing below, you are verifying that you do, in fact, have one or more of the conditions listed above and have met any additional requirements for that condition(s) and are eligible for vaccination at this time.

____ ____________________

PATIENT SIGNATURE (or parent/guardian if patient is age 17 or under) **Date**