

BUTLER COUNTY GENERAL HEALTH DISTRICT COVID-19 Vaccine Registration Form

FIRST SHOT
****Date** _____
 SECOND SHOT

<input type="checkbox"/> Moderna	<input type="checkbox"/> Janssen (Johnson & Johnson) 1-dose	<input type="checkbox"/> Pfizer	<input type="checkbox"/> Pedi Pfizer 5-11 y/o
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FIRST NAME		MIDDLE INITIAL	LAST NAME		TODAY'S DATE / /
*****DATE OF BIRTH***** / /		**AGE**	**18 OR OLDER?** <input type="checkbox"/> Yes <input type="checkbox"/> No	**RACE** <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	
*****PHONE NUMBER*****		*****EMAIL*****			
STREET ADDRESS					
CITY		STATE	ZIP	COUNTY OF RESIDENCE	

INSURANCE If you have health insurance: _____ **Member ID #:** _____
 Buckeye, Care Source, Molina, Paramount, Ohio Medicaid, UHC Community, Aetna, Anthem, United Health Care

1. Are you feeling sick today?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. If yes, which vaccine product? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (JnJ) <input type="checkbox"/> Other _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Was the severe allergic reaction after receiving a COVID-19 vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
6. Was the severe allergic reaction after receiving another vaccine or another injectable medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? (Must wait 90 days after infusion to get COVID vaccine)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
8. Have you received any type of vaccine in the last 14 days?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
9. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
10. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
11. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
12. Are you pregnant or breastfeeding?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

IF YOU SAID YES TO QUESTIONS 4, 5 or 6 YOU WILL NEED TO WAIT 30 MINUTES AFTER RECEIVING VACCINE.

What group are you in? (select only one)

<input type="checkbox"/> Assisted Living Facility Resident	<input type="checkbox"/> Hospital worker Administrative Staff
<input type="checkbox"/> Assisted Living Facility Staff	<input type="checkbox"/> Hospital worker Ancillary Staff
<input type="checkbox"/> Skilled Nursing Facility (RCF) Resident	<input type="checkbox"/> Non-Hospital healthcare worker Clinical Staff
<input type="checkbox"/> Skilled Nursing Facility (RCF) Staff	<input type="checkbox"/> Non-Hospital healthcare worker Administrative Staff
<input type="checkbox"/> State of Ohio DODD Resident	<input type="checkbox"/> Non-Hospital healthcare worker Ancillary Staff
<input type="checkbox"/> State of Ohio DODD Staff	<input type="checkbox"/> Emergency Medical Services EMTs/Paramedics
<input type="checkbox"/> State of Ohio Veterans Home Resident	<input type="checkbox"/> Law Enforcement, Corrections, Firefighter
<input type="checkbox"/> State of Ohio Veterans Home Staff	<input type="checkbox"/> Individual with congenital disorders or early onset conditions
<input type="checkbox"/> State of Ohio MHAS Resident	<input type="checkbox"/> Funeral Services Worker
<input type="checkbox"/> State of Ohio MHAS Staff	<input type="checkbox"/> Childcare Services Worker
<input type="checkbox"/> State of Ohio DRC LTC residents	<input type="checkbox"/> Individual working in K-12 schools
<input type="checkbox"/> State of Ohio DRC LTC staff	<input type="checkbox"/> Individual age 5-11 years of age
<input type="checkbox"/> Congregate Care Facility Resident	<input type="checkbox"/> Individual age 12-17 years of age
<input type="checkbox"/> Congregate Care Facility Staff	<input type="checkbox"/> Individual over 18 years of age
<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Individual over 40 years of age
<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Individual over 50 years of age

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| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Individual over 60 years of age |
| <input type="checkbox"/> ALS (Amyotrophic lateral sclerosis) | <input type="checkbox"/> Individual over 65 years of age |
| <input type="checkbox"/> Bone Marrow Transplant Recipient | <input type="checkbox"/> Individual over 70 years of age |
| <input type="checkbox"/> Acute Renal Failure | <input type="checkbox"/> Individual over 75 years of age |
| <input type="checkbox"/> Hospital worker Clinical Staff | <input type="checkbox"/> Individual over 80 years of age |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Chronic Obstructive Pulmonary Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Chronic Kidney Disease (CKD) | <input type="checkbox"/> Obesity |
| | <input type="checkbox"/> Other _____ |

I certify that I am the patient at least 18 years old, the parent or legal guardian of the patient who is under 18 years old or the legal guardian of the patient who is over 18 years old. I was given an explanation about the diseases and vaccines circled below. I had the opportunity to ask questions that were answered to my satisfaction and I have received the Vaccine Information Sheet(s). I understand the benefits and risks of the vaccine(s) and further understand it is not possible all possible to predict all possible side effects or complications associated with receiving a vaccine(s). I give my permission for myself, my child or my ward to be vaccinated by the Butler County Health Department. I am authorized to make this request for the above named person.

I hereby release and hold harmless the Butler County Health Department and all other applicable providers, their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) circled below including but not limited to adverse reactions to the vaccine, harm resulting from the administration of the vaccine and any other harm which may arise at the location in which the vaccine is administered which is in any way associated with the vaccination which I have freely and voluntarily requested. I authorize the release of this record to the Ohio Department of Health Immunization Program, my/my child's health care provider, and school. I hereby acknowledge receipt of, or decline the Notice of Health Information Privacy Practices, HIPPA. I give my permission for the filing of claims with my insurance company.

After receiving this vaccine we recommend you wait 15 minutes, unless otherwise identified to wait 30 minutes. If you leave the vaccination site before 15 or 30 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 (parent/guardian if under age 18, or is your ward)*****

DATE

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

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 <input type="checkbox"/> Janssen (Johnson & Johnson) 1-dose <input type="checkbox"/> Pfizer
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"/> Left Arm <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Thigh	DOSE IN SERIES <input type="checkbox"/> First <input type="checkbox"/> Second	SERIES COMPLETE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
VACCINATOR	NOTES			
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)	

ADULT VACCINES (CIRCLE ONE)	Admin Codes (CIRCLE ONE)	CVX Code (CIRCLE ONE)	CPT Code (CIRCLE ONE)
SARS-COV-2 Vaccine			
Pfizer: mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use (2-doses required) with counseling	0001A (1 st dose) 0002A (2 nd dose)	208	91300
Moderna: mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use (2 doses required) with counseling	0011A (1 st dose) 0012A (2 nd dose)	207	91301
Janssen (Johnson & Johnson): vector-nr, rS-Ad26, preservative free, 0.5 mL dosage, for intramuscular use, (1 dose required) with counseling	0031A (1 dose)	212	91303

Pfizer 5-11 y/o: mRNA-LNP, spike protein, preservative free, 10 mcg/0.2mL dosage, tris-sucrose formulation, diluent reconstituted, for intramuscular use (2-doses required) with counseling	0071A (1 st dose) 0072A (2 nd dose)	218	91307
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