

COVID-19 Vaccine Administration Record and Informed Consent

PATIENT INFORMATION – Please complete				
LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	AGE
STREET ADDRESS		CITY	STATE	ZIP
EMAIL ADDRESS		PHONE NUMBER	COUNTY OF RESIDENCE	
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"/> Non-Hispanic/Latino (2) <input type="checkbox"/> Unknown (3)	ALLERGIES: <input type="checkbox"/> No known allergies <input type="checkbox"/> YES (please specify):	SEX <input type="checkbox"/> Female (F) <input type="checkbox"/> Male (M) <input type="checkbox"/> Other (O) <input type="checkbox"/> Unknown (U)	
PRESCRIPTION INSURANCE INFORMATION – Please complete				
RX BIN		RX GROUP	MEDICARE B ID NUMBER (Red, white, and blue card)	
RX PCN		RX OR MEMBER ID	SOCIAL SECURITY NUMBER	
TARGET POPULATION / OCCUPATION CODES – Please complete				
<input type="checkbox"/> TPV1: Assisted Living: Resident <input type="checkbox"/> TPV2: Assisted Living: Staff <input type="checkbox"/> TPV3: Skilled Nursing: Resident <input type="checkbox"/> TPV4: Skilled Nursing: Staff <input type="checkbox"/> TPV5: State of Ohio DODD: Resident <input type="checkbox"/> TPV6: State of Ohio DODD: Staff <input type="checkbox"/> TPV7: State of Ohio Veterans Home: Resident <input type="checkbox"/> TPV8: State of Ohio Veterans Home: Staff <input type="checkbox"/> TPV9: State of Ohio MHAS: Resident <input type="checkbox"/> TPV10: State of Ohio MHAS: Staff <input type="checkbox"/> TPV11: State of Ohio DRC LTC: Resident <input type="checkbox"/> TPV12: State of Ohio DRC LTC: Staff <input type="checkbox"/> TPV13: Congregate Care: Resident <input type="checkbox"/> TPV14: Congregate Care: Staff <input type="checkbox"/> TPV15: Hospital: Clinical Staff <input type="checkbox"/> TPV16: Hospital: Administrative Staff <input type="checkbox"/> TPV17: Hospital: Ancillary Staff	<input type="checkbox"/> TPV18: Non-hospital healthcare: Administrative Staff <input type="checkbox"/> TPV19: Non-hospital healthcare: Ancillary Staff <input type="checkbox"/> TPV20: Non-hospital healthcare: Clinical Staff <input type="checkbox"/> TPV21: EMS/EMT/Paramedics <input type="checkbox"/> TPV22: Individuals congenital disorders or early onset conditions with intellectual and developmental disabilities <input type="checkbox"/> TPV23: Working K-12 schools <input type="checkbox"/> TPV24: Individuals congenital disorders or early onset conditions without intellectual and developmental disabilities <input type="checkbox"/> TPV25: Type 1 Diabetes <input type="checkbox"/> TPV26: Pregnant <input type="checkbox"/> TPV27: Bone Marrow Transplant <input type="checkbox"/> TPV28: ALS <input type="checkbox"/> TPV29: Childcare Services Worker	<input type="checkbox"/> TPV30: Funeral Services Worker <input type="checkbox"/> TPV31: Law Enforcement, Corrections, Firefighter <input type="checkbox"/> TPV32: Type 2 Diabetes <input type="checkbox"/> TPV33: End Stage Renal Disease <input type="checkbox"/> TPV34: Cancer <input type="checkbox"/> TPV35: Chronic Kidney Disease <input type="checkbox"/> TPV36: Chronic Obstructive Pulmonary Disease <input type="checkbox"/> TPV37: Heart Disease <input type="checkbox"/> TPV38: Obesity <input type="checkbox"/> TPVALL: Individuals 5 to 11 years <input type="checkbox"/> TPVALL: Individuals 12 to 39 years <input type="checkbox"/> TPV40: Individuals 40 to 49 years <input type="checkbox"/> TPV50: Individuals 50 to 59 years <input type="checkbox"/> TPV60: Individuals 60 to 64 years <input type="checkbox"/> TPV65: Individuals 65 to 69 years <input type="checkbox"/> TPV70: Individuals 70 to 74 years <input type="checkbox"/> TPV75: Individuals 75 to 79 years <input type="checkbox"/> TPV80: Individuals over 80 years		
CONSENT – BY SIGNING BELOW, YOU AGREE THAT YOU:				
<ol style="list-style-type: none"> 1. Have received copy of Emergency Use Authorization (EUA) for the COVID-19 Vaccine 2. Understand the benefits and risks of the vaccine 3. Consent for the person named on this form to receive the COVID-19 Vaccine 4. Acknowledge the receipt of vaccination and prescription on the indicated date below 5. Consent that ONU HealthWise may bill your insurance, if applicable 6. Authorize the release of this vaccination record and all information on this form to Ohio's immunization program/CDC 7. Agree to hold Ohio Northern University and employees harmless should an unforeseen or untoward reaction occur. It is your intention by this instrument to exempt and relieve Ohio Northern University and its employees from liability for personal injury, bodily injury, or wrongful death caused from the administration of this vaccine 				
SIGNATURE (<i>patient or legal guardian if < 18 years old</i>)			DATE	

SCREENING QUESTIONS – Please complete			
1. Are you under 18 years old? *If less than 18 years old, legal guardian or parent must sign consent form	<input type="checkbox"/> NO	<input type="checkbox"/> YES → Reminded of the importance of a well-child visit	
2. Have you recently had a fever or above-normal temperature? <i>Temperature today:</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
3. Are you feeling sick today?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
4. Have you ever had a positive test for COVID-19 or has your doctor ever told you that you had COVID-19?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
6. Have you ever had an allergic reaction (anaphylaxis, hives, swelling, respiratory distress) to:			
a. A component of the COVID-19 vaccine, including polyethylene glycol (PEG)	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
b. Polysorbate	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
c. Previous dose of COVID-19 vaccine	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
d. Previous vaccination	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
7. Have you received a vaccine in the last 14 days?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
8. Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
9. Do you have a weakened immune system caused by something such as HIV infection, cancer, immunosuppressive therapy?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
10. Do you currently have or have had myocarditis and myopericarditis?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
11. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
12. Are you pregnant or breastfeeding?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN
13. Do you have any serious health conditions (often called co-morbidities)?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN

FOR CLINIC USE ONLY:

PATIENT NAME		DATE OF BIRTH	VERIFICATION OF IDENTITY <input type="checkbox"/> Yes <input type="checkbox"/> No
DATE OF LAST DOSE / / Today's DOSE NUMBER		<input type="checkbox"/> I verify that a pharmacist has reviewed Ohio ImpactSIS prior to ordering and administering this vaccine	
VACCINE ADMINISTRATION RECORD			
MANUFACTURER/VACCINE <input type="checkbox"/> Janssen COVID-19 Vaccine <input type="checkbox"/> Moderna COVID-19 Vaccine <input type="checkbox"/> Pfizer COVID-19 Vaccine <input type="checkbox"/> PEDS Pfizer COVID-19 Vaccine	VACCINE LOT	VACCINE EXPIRATION	DATE OF VACCINATION
ADMINISTRATION <input type="checkbox"/> Left deltoid (IM) <input type="checkbox"/> Right deltoid (IM)	NEEDLE <input type="checkbox"/> 5/8 inch, 25 G <input type="checkbox"/> 1 inch, 25 G <input type="checkbox"/> 1 ½ inch, 25 G	CLINIC LOCATION: <input type="checkbox"/> ONU HealthWise Pharmacy 511 W. Lincoln Ave. Ada, Ohio 45810 <input type="checkbox"/> Mobile Clinic Location:	
VACCINE ADMINISTRATOR, <u>Pharmacy Intern</u>		VACCINE ADMINISTRATOR OR PRECEPTOR, <u>Pharmacist</u>	



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