HealthWise PHARMACY OHIO NORTHERN UNIVERSITY

COVID-19 Vaccine Administration Record and Informed Consent

PATIENT INFORMATION				
LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	AGE
STREET ADDRESS		CITY	STATE	ZIP
EMAIL ADDRESS		PHONE NUMBER	COUNTY OF RESIDENCE	

RACE	ETHNICITY	ALLERGIES:	SEX
☐ Alaskan Native (5) ☐ American Indian (5) ☐ Asian (4) ☐ Black (2) ☐ Native Hawaiian (7) ☐ Pacific Islander (7) ☐ White (1) ☐ Other (6) ☐ Unknown (9)	☐ Hispanic/Latino (1) ☐ Non-Hispanic/Latino (2) ☐ Unknown (3)	☐ No known allergies ☐ YES:	☐ Female (F) ☐ Male (M) ☐ Other (O) ☐ Unknown (U)
	RX BIN	RX GROUP	MEDICARE B (RWB)
	RX PCN	RX ID	SOCIAL SECURITY NUMBER

TARGET POPULATION / OCCUPATION CODES		
☐ TPV1: Assisted Living: Resident ☐ TPV2: Assisted Living: Staff ☐ TPV3: Skilled Nursing: Resident ☐ TPV4: Skilled Nursing: Staff ☐ TPV5: State of Ohio DODD: Resident ☐ TPV6: State of Ohio DODD: Staff ☐ TPV7: State of Ohio Veterans Home: Resident ☐ TPV8: State of Ohio Veterans Home: Staff ☐ TPV9: State of Ohio MHAS: Resident ☐ TPV10: State of Ohio MHAS: Staff ☐ TPV11: State of Ohio DRC LTC: Resident ☐ TPV12: State of Ohio DRC LTC: Staff ☐ TPV13: Congregate Care: Resident ☐ TPV14: Congregate Care: Staff ☐ TPV15: Hospital: Clinical Staff ☐ TPV16: Hospital: Administrative Staff ☐ TPV17: Hospital: Ancillary Staff	☐ TPV18: Non-hospital healthcare: Administrative Staff ☐ TPV19: Non-hospital healthcare: Ancillary Staff ☐ TPV20: Non-hospital healthcare: Clinical Staff ☐ TPV21: EMS/EMT/Paramedics ☐ TPV22: Individuals congenital disorders or early onset conditions with intellectual and developmental disabilities ☐ TPV23: Working K-12 schools ☐ TPV24: Individuals congenital disorders or early onset conditions without intellectual and developmental disabilities ☐ TPV25: Type 1 Diabetes ☐ TPV26: Pregnant ☐ TPV27: Bone Marrow Transplant ☐ TPV28: ALS	☐ TPV29: Childcare Services Worker ☐ TPV30: Funeral Services Worker ☐ TPV31: Law Enforcement, Corrections, Firefighter ☐ TPV32: Type 2 Diabetes ☐ TPV33: End Stage Renal Disease ☐ TPV34: Cancer ☐ TPV35: Chronic Kidney Disease ☐ TPV36: Chronic Obstructive Pulmonary Disease ☐ TPV37: Heart Disease ☐ TPV38: Obesity ☐ TPVALL: Individuals 12 to 39 years ☐ TPV40: Individuals 40 to 49 years ☐ TPV50: Individuals 50 to 59 years ☐ TPV60: Individuals 60 to 64 years ☐ TPV65: Individuals 65 to 69 years ☐ TPV70: Individuals 70 to 74 years ☐ TPV75: Individuals 75 to 79 years ☐ TPV80: Individuals over 80 years

PATIENT CONSENT

By signing below, you agree that you:

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

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	DATE

PATIENT NAME	DATE OF BIRTH	VERIFICATION OF IDENTITY ☐ Yes ☐ No

SCREENING QUESTIONS			
1. Are you ≤ 18 years of age?	☐ NO	☐ YES → I certify that the patient and/or caregiver were reminded of the importance of a well-child visit and provided more information if needed	
2. Have you recently had a fever or above-normal temperature? *Temperature today:*	☐ NO	☐ YES	☐ UNKNOWN
3. Are you feeling sick today?	☐ NO	☐ YES	☐ UNKNOWN
4. Have you ever had a positive test for COVID-19 or has your doctor ever told you that you had COVID-19?	☐ NO	☐ YES	☐ UNKNOWN
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ NO	☐ YES	☐ 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)	☐ NO	☐ YES	☐ UNKNOWN
b. Polysorbate	☐ NO	☐ YES	☐ UNKNOWN
c. Previous dose of COVID-19 vaccine	☐ NO	☐ YES	☐ UNKNOWN
d. Previous vaccination	☐ NO	☐ YES	☐ UNKNOWN
e. Something else (food, pet, environmental, oral medication)	☐ NO	☐ YES	☐ UNKNOWN
7. Have you received a vaccine in the last 14 days?	☐ NO	☐ YES	☐ UNKNOWN
8. Have you ever received a dose of COVID-19 vaccine?	☐ NO	☐ YES	☐ UNKNOWN
9. Do you have a weakened immune system caused by something such as HIV infection, cancer, immunosuppressive therapy?	☐ NO	☐ YES	☐ UNKNOWN
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐ NO	☐ YES	☐ UNKNOWN
11. Are you pregnant or breastfeeding?	☐ NO	☐ YES	☐ UNKNOWN
12. Do you have any serious health conditions (often called co-morbidities)?	☐ NO	☐ YES	☐ UNKNOWN

VACCINE ADMINISTRATION RECORD			
MANUFACTURER/VACCINE ☐ Janssen COVID-19 Vaccine ☐ Moderna COVID-19 Vaccine ☐ Pfizer-BioNTech COVID-19 Vaccine	VACCINE LOT	VACCINE EXPIRATION	DATE OF VACCINATION
ADMINISTRATION ☐ Left deltoid (IM) ☐ Right deltoid (IM)	NEEDLE ☐ 5/8 inch, 25 G ☐ 1 inch, 25 G ☐ 1 ½ inch, 25 G	CLINIC LOCATION: ☐ HealthWise Pharmacy 511 W. Lincoln Ave Ada, Ohio 45810	☐ Mobile Health Clinic:
VACCINE ADMINISTRATOR, Pharmacy Intern		VACCINE ADMINISTRATOR OR PRECEPTOR, Pharmacist ☐ *I verify that a pharmacist has reviewed Ohio ImpactSIIS prior to ordering and administering this vaccine*	