COVID-19 Vaccine Administration Record and Informed Consent

HealthWise PHARMACY OHIO NORTHERN UNIVERSITY

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
- ☐ 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)
- ☐ Non-Hispanic/Latino (2)
- ☐ Unknown (3)

ALLERGIES:
- ☐ No known allergies
- ☐ YES:

SEX
- ☐ Female (F)
- ☐ Male (M)
- ☐ Other (O)
- ☐ Unknown (U)

PRESCRIPTION INSURANCE INFORMATION – Please complete		
RX BIN	RX GROUP	MEDICARE B ID NUMBER (Red, white, and blue card)
RX PCN	RX ID	SOCIAL SECURITY NUMBER

TARGET POPULATION / OCCUPATION CODES – Please complete

- ☐ 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 5 to 11 years
- ☐ 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

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
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	DATE

SCREENING QUESTIONS – Please complete			
1. Are you under 18 years old?	☐ NO	☐ YES → Reminded of the importance of a well-child visit	
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
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 currently have or have had myocarditis and myopericarditis?	☐ NO	☐ YES	☐ UNKNOWN
11. Do you have a bleeding disorder or are you taking a blood thinner?	☐ NO	☐ YES	☐ UNKNOWN
12. Are you pregnant or breastfeeding?	☐ NO	☐ YES	☐ UNKNOWN
13. Do you have any serious health conditions (often called co-morbidities)?	☐ NO	☐ YES	☐ UNKNOWN

FOR CLINIC USE ONLY:

PATIENT NAME	DATE OF BIRTH	VERIFICATION OF IDENTITY ☐ Yes ☐ No
DATE OF LAST DOSE / / Today's DOSE NUMBER	☐ *I verify that a pharmacist has reviewed Ohio ImpactSIIS prior to ordering and administering this vaccine*	

VACCINE ADMINISTRATION RECORD			
MANUFACTURER/VACCINE ☐ Janssen COVID-19 Vaccine ☐ Moderna COVID-19 Vaccine ☐ Pfizer 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: ☐ ONU HealthWise Pharmacy 511 W. Lincoln Ave. Ada, Ohio 45810 ☐ Mobile Clinic Location:	
VACCINE ADMINISTRATOR, Pharmacy Intern		VACCINE ADMINISTRATOR OR PRECEPTOR, Pharmacist	

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