AUGLAIZE COUNTY HEALTH DEPARTMENT
prevent. promote. protect.

Name: Last, First, MI			Date of Birth		Age
Address	**City**		**State**	**Zip**	**County**
Phone	**Sex**	**Race:** - Native American or Alaskan -Asian - African American or Black - Declined - Native Hawaiian or Pacific Islander -White -Other		**Ethnicity:** -Declined - Hispanic Origin -Non-Hispanic Origin - Unknown	
Client SS#					

Please answer the following questions to the best of your knowledge:	YES	NO
1. Are feeling sick today?	□	□
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine? _____	□	□
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or taken to the hospital?	□	□
a. Was the severe allergic reaction after receiving a COVID-19 vaccine?	□	□
b. Was the severe allergic reaction after receiving another vaccine or injected medication?	□	□
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	□	□
5. Have you received another vaccine in the last 14 days?	□	□
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	□	□
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	□	□
8. Do you have a bleeding disorder or are you taking a blood thinner?	□	□
9. For women, are you pregnant or breastfeeding?	□	□

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have been provided and have read, or had explained to me, the Fact Sheet for Recipients and Caregivers about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries. I understand an appointment reminder or missed appointment notice may be sent by postcard or letter in the mail, telephone / answering machine or voicemail, or text message.

Patient/Parent/Legal Guardian Name: _____ Date:_____

STAFF USE BELOW

	Vaccine/EUA Fact Sheet	Date Given	Manufacturer	Lot#	Injection Site	Administrator
					LT RT LD RD	

Select all that apply:

_____I request ACHD to bill my **Insurance or Medical Coverage Plan** for the Administration fee only.
_____I will pay cash/check at the time of service for the Administration fee only.
_____My employer will be paying for the Administration fee. Employer: _____

Insurance Information:

Primary Insurance	
Name of Insurance:	Policy Holder's Name:
Relationship to Patient:	Policy Holder's Employer:
Policy Holder's Phone #:	Policy Holder's Date of Birth:
Secondary Insurance (*)	
Name of Insurance:	Policy Holder's Name:
Relationship to Patient:	Policy Holder's Employer:
Policy Holder's Phone #:	Policy Holder's Date of Birth:

Patient/Parent/Legal Guardian Name: _____ Date:_____

Occupation Data Checklist for COVID-19 Vaccine Recipients: Please **check only one** box in the section below. Please select the primary reason you are receiving the COVID-19 Vaccine.

□	Assisted Living Facility – Resident	□	Congregate Care Facility – Resident
□	Assisted Living Facility – Staff	□	Congregate Care Facility – Staff
□	Skilled Nursing Facility (RCF) – Resident	□	Hospital Worker – Clinical Staff
□	Skilled Nursing Facility (RCF) – Staff	□	Hospital Worker – Administrative Staff
□	State of Ohio Dept. of Dev. Disabilities (DODD) - Resident	□	Hospital Worker – Ancillary Staff
□	State of Ohio Dept. of Dev. Disabilities (DODD) - Staff	□	Non-Hospital healthcare worker – Administrative Staff
□	State of Ohio Veterans Home - Resident	□	Non-Hospital healthcare worker – Ancillary Staff
□	State of Ohio Veterans Home - Staff	□	Non-Hospital healthcare worker – Clinical Staff
□	State of Ohio Mental Health and Addiction Services (MHAS) - Resident	□	Emergency Medical Services (EMTs/Paramedics)
□	State of Ohio Mental Health and Addiction Services (MHAS) - Staff	□	State of Ohio Dept. of Rehabilitation & Correction – LTC Staff
□	State of Ohio Dept. of Rehabilitation & Correction – LTC Residents		

12/23/2020