AUGLAIZE COUNTY HEALTH DEPARTMENT
prevent. promote. protect.

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

Please answer the following questions to the best of your knowledge:

	Yes	No	Don't Know
1. Are feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine (circle one) Moderna, Pfizer, Janssen (Johnson & Johnson), Another Product _____	☐	☐	☐
3. Have you ever had a severe allergic reaction to: **(This would include a severe allergic reaction [e.g. anaphylaxis] that required treatment with epinephrine or EpiPen, or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)**			
• **A component of the COVID-19 vaccine, including either of the following:**			
○ **Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures.**	☐	☐	☐
○ **Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.**	☐	☐	☐
• **A previous dose of COVID-19 vaccine**	☐	☐	☐
• **A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.**	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? **(This would include a severe allergic reaction [e.g. anaphylaxis] that required treatment with epinephrine or EpiPen, or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)**	☐	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to <u>something other</u> than a component of COVID-19 vaccine, or any vaccine or injectable medication? <u>This would include food, pet, venom, environmental, or oral medication allergies.</u>	☐	☐	☐
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. For women, are you pregnant or breastfeeding?	☐	☐	☐
12. Do you have dermal fillers?	☐	☐	☐

Form Reviewed by Staff/Volunteer Member: _____ Date:_____

Additional notes: _____

Insurance Information: Please complete and have all insurance cards (Primary & Secondary) available at your appointment

Primary Insurance	
Name of Insurance:	Policy Holder's Employer
Policy Holder's Name:	Relationship to Patient:
Policy Holder's Address:	
Policy Holder's Phone #:	Policy Holder's Date of Birth:

Target Population/Occupation Checklist for COVID-19 Vaccine Recipients: Please **check only one** box in the section below.

□	Assisted Living Facility Resident (TPV1)	□	Congregate Care Facility Staff (TPV14)	□	Individuals working in K-12 schools (TPV23)
□	Assisted Living Facility Staff (TPV2)	□	Hospital worker Clinical Staff (TPV15)	□	Individuals with Congenital Disorders or Early in Life Conditions that carried into Adulthood without IDD (TPV24)
□	Skilled Nursing Facility Resident (TPV3)	□	Hospital worker Administrative Staff (TPV16)		
□	Skilled Nursing Facility Staff (TPV4)	□	Hospital worker Ancillary Staff (TPV17)	□	Diabetes Type 1 (TPV25)
□	State of Ohio DODD Resident (TPV5)	□	Non-Hospital healthcare worker Clinical Staff (TPV20)	□	Pregnant (TPV26)
□	State of Ohio DODD Staff (TPV6)	□	Non-Hospital healthcare worker Administrative Staff (TPV18)	□	Bone Marrow Transplant Recipient (TPV27
□	State of Ohio Veterans Home Resident (TPV7)	□	Non-Hospital healthcare worker Ancillary Staff (TPV19)	□	ALS (TPV28)
□	State of Ohio Veterans Home Staff (TPV8)	□	Emergency Medical Services EMTs/Paramedics (TPV21)	□	Childcare Services Worker (TPV29)
□	State of Ohio MHAS Resident (TPV9)	□	Individuals over 80 years of age (TPV80)	□	Funeral Services Worker (TPV30)
□	State of Ohio MHAS Staff (TPV10)	□	Individuals age 75 to 79 years of age (TPV75)	□	Law Enforcement, Corrections, Firefighter (TPV31)
□	Sate of Ohio DRC LTC Resident (TPV11)	□	Individuals age 70 to 74 years of age (TPV70)	□	Diabetes Type 2 (TPV32)
□	State of Ohio DRC LTC Staff (TPV12)	□	Individuals age 65 to 69 years of age (TPV65)	□	End Stage Renal Disease (TPV33)
□	Congregate Care Facility Resident (TPV13)	□	Individuals with congenital disorders or early onset condition with IDD (TPV22)	□	Individuals age 60 to 64 years of age (TPV 60)
□	Cancer (TPV34)	□	Chronic Kidney Disease (TPV35)	□	Individuals age 50 to 59 years of age (TPV50)
□	Obesity (TPV38)	□	Heart Disease (TPV37)	□	Individuals age 40 to 49 years of age (TPV40)
□	Chronic Obstructive Pulmonary Disease (TPV36)			□	Individuals age 16 to 39 years of age (TPVALL)

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 (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. I acknowledge having a chance to review & keep the Auglaize County Health Department (ACHD) Notice of Privacy Practices. Copies of the Privacy Notice are displayed in the Health Department or on their website. I understand the terms of the Privacy Notice may change and I may get these changed notices by contacting ACHD by phone or in writing. I understand I have the right to ask how my protected health information will be used and / or given out.

Patient/Parent/Legal Guardian Consent /Signature:

X _____**Date:**_____

STAFF USE BELOW

	Vaccine/EUA Fact Sheet	Date Given	Manufacturer	Lot#	Injection Site	Administrator
	COVID-19				LT RT LD RD	