Clinic: Oklahoma City-County Health Department Today's Date: _____

COVID-19 Vaccination Form

Please complete each field below with the information that applies to the client receiving services today.

CLIENT INFORMATION

Name (Last, First, MI)	**Suffix (eg., Jr, III)**	**Date of Birth**	**Age†**
, ,			

Street Address	**City**	**State**	**Zip**	**County**

Phone Number ☐ Cell ☐ Home ( )	**Sex at birth** ☐ Female ☐ Male	**Gender Identity** ☐ Female ☐ Male ☐Non-binary ☐ Unknown ☐ Prefer not to say

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

SCREENING FOR VACCINE ELIGIBILTY

	YES	NO
Has the patient ever received a dose of the COVID-19 Pfizer-BioNTech vaccine?		
Has the patient ever had an allergic reaction to: ☐ a component of a COVID-19 vaccine, including either of the following: -polyethylene glycol (PEG), which is found in some medications, such as laxatives and preps 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 component, but it is not known which component elicited the immediate reaction ☐ another vaccine (other than COVID-19 vaccine) or an injectable medication?		
Has the patient ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.		
Does the patient have a history of myocarditis or pericarditis?		
Has the patient ever had COVID-19 and been treated with monoclonal antibodies or convalescent plasma?		

CONSENT FOR SERVICE

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma City-County Health Department (OCCHD) and its entities/contractors. I understand that:

-- the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions.

-- the information regarding myself and the services I receive will be entered into OCCHD management information systems and may be used for program evaluation, management, and billing purposes.

-- I may refuse service at any time.

I acknowledge that for health and safety reasons masks must be worn at all times during a vaccination event. By signing this form, I hereby agree to wear a mask during the vaccination event with OCCHD.

I acknowledge that I can access a copy of the Oklahoma City-County Health Department HIPAA Privacy Notice as required by the Health Information Portability and Accountability Act (HIPAA) at https://www.occhd.org/about/contact-us/hipaa. I also acknowledge that I received the manufacturer-specific Fact Sheet for Recipients and Caregivers prior to receiving the vaccine. This information can also be accessed at https://www.vaxokc.com/eua.

Client Signature: _____ Date: _____

†Client must be aged 12 years or older to receive the Pfizer vaccine and aged 18 years or older to receive the Moderna or Johnson & Johnson vaccine.

****FOR OFFICIAL USE ONLY****

Client Name (Last, First, MI) _____ Client DOB (MM/DD/YYYY)_____

OFFICE USE ONLY – DO NOT WRITE BELOW			
Ask before administration: Is the client suffering from a moderate or severe acute illness with or without fever? ☐ Y ☐ N Is the client pregnant? ☐ Y ☐ N Client completed the manufacturer's screening questions: ☐ Y ☐ N			
Vaccine Manufacturer: Lot #: Exp. Date:	Site: ☐ LT DELTOID IM ☐ RT DELTOID IM ☐ LT VAST LAT IM ☐ RT VAST LAT IM	EUA*/VIS given? ☐ Y ☐ N Reaction? ☐ Y ☐ N	Dose Number: ☐ 1st ☐ 2nd
Vaccination Complete? ☐Complete ☐Refused ☐Not administered ☐Partially administered ☐No recorded completion status			
Provider Signature:			

*EAU = Emergency Use Agreement

Progress Note:_____

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