BUTLER COUNTY GENERAL HEALTH DISTRICT
COVID-19 Vaccine Registration Form

☐ FIRST SHOT
**Date _____
☐ SECOND SHOT

FIRST NAME	MIDDLE INITIAL	LAST NAME	TODAY'S DATE
			/ /

*******DATE OF BIRTH******	**AGE**	**18 OR OLDER?**	**RACE**	ETHNICITY
/ /		☐ Yes ☐ No	☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Other	☐ Hispanic/Latino ☐ Not Hispanic/Latino **SEX** ☐ Female ☐ Male ☐ Other

*******PHONE NUMBER*******	*******EMAIL**********	STREET ADDRESS

CITY	STATE	ZIP	COUNTY OF RESIDENCE

INSURANCE **If you have health insurance:** **Member ID #:**
Buckeye, Care Source, Molina, Paramount, Ohio Medicaid, UHC Community, Aetna, Anthem, United Health Care

1. Are you feeling sick today?	☐ No	☐ **Yes**	
2. Have you ever received a dose of COVID-19 vaccine?	☐ No	☐ **Yes**	
3. **If yes, which vaccine product?** ☐ Pfizer ☐Moderna ☐ Janssen (JnJ) ☐ Other_____	☐ No	☐ **Yes**	
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something?	☐ No	☐ **Yes**	
5. Was the severe allergic reaction after receiving a COVID-19 vaccine?	☐ No	☐ **Yes**	☐ N/A
6. Was the severe allergic reaction after receiving another vaccine or another injectable medication?	☐ No	☐ **Yes**	☐ N/A
7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? **(Must wait 90 days after infusion to get COVID vaccine)**	☐ No	☐ **Yes**	
8. Have you received any type of vaccine in the last 14 days? **(Must wait 14 days from ANY injection)**	☐ No	☐ **Yes**	
9. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐ No	☐ **Yes**	
10. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ No	☐ **Yes**	
11. Do you have a bleeding disorder or are you taking a blood thinner?	☐ No	☐ **Yes**	
12. Are you pregnant or breastfeeding?	☐ No	☐ **Yes**	

IF YOU SAID YES TO QUESTIONS 4, 5 or 6 YOU WILL NEED TO WAIT 30 MINUTES AFTER RECEIVING VACCINE.

What group are you in? (select only one)

☐ Assisted Living Facility Resident
☐ Assisted Living Facility Staff
☐ Skilled Nursing Facility (RCF) Resident
☐ Skilled Nursing Facility (RCF) Staff
☐ State of Ohio DODD Resident
☐ State of Ohio DODD Staff
☐ State of Ohio Veterans Home Resident
☐ State of Ohio Veterans Home Staff
☐ State of Ohio MHAS Resident
☐ State of Ohio MHAS Staff
☐ State of Ohio DRC LTC residents
☐ State of Ohio DRC LTC staff
☐ Congregate Care Facility Resident
☐ Congregate Care Facility Staff
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Pregnant
☐ ALS (Amyotrophic lateral sclerosis)
☐ Bone Marrow Transplant Recipient
☐ Hospital worker Administrative Staff
☐ Hospital worker Ancillary Staff
☐ Non-Hospital healthcare worker Clinical Staff
☐ Non-Hospital healthcare worker Administrative Staff
☐ Non-Hospital healthcare worker Ancillary Staff
☐ Emergency Medical Services EMTs/Paramedics
☐ Law Enforcement, Corrections, Firefighter
☐ Individual with congenital disorders or early onset conditions
☐ Funeral Services Worker
☐ Childcare Services Worker
☐ Individual working in K-12 schools
☐ Individual over 18 years of age
☐ Individual over 40 years of age
☐ Individual over 50 years of age
☐ Individual over 60 years of age
☐ Individual over 65 years of age
☐ Individual over 70 years of age
☐ Individual over 75 years of age
☐ Individual over 80 years of age
☐ Chronic Obstructive Pulmonary Disease

☐ Acute Renal Failure
☐ Hospital worker Clinical Staff
☐ End Stage Renal Disease
☐ Cancer
☐ Chronic Kidney Disease (CKD)
☐ Heart Disease
☐ Obesity
☐ Other _____

I certify that I am the patient at least 18 years old, the parent or legal guardian of the patient who is under 18 years old or the legal guardian of the patient who is over 18 years old. I was given an explanation about the diseases and vaccines circled below. I had the opportunity to ask questions that were answered to my satisfaction and I have received the Vaccine Information Sheet(s). I understand the benefits and risks of the vaccine(s) and further understand it is not possible all possible to predict all possible side effects or complications associated with receiving a vaccine(s). I give my permission for myself, my child or my ward to be vaccinated by the Butler County Health Department. I am authorized to make this request for the above named person.

I hereby release and hold harmless the Butler County Health Department and all other applicable providers, their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) circled below including but not limited to adverse reactions to the vaccine, harm resulting from the administration of the vaccine and any other harm which may arise at the location in which the vaccine is administered which is in any way associated with the vaccination which I have freely and voluntarily requested. I authorize the release of this record to the Ohio Department of Health Immunization Program, my/my child's health care provider, and school. I hereby acknowledge receipt of, or decline the Notice of Health Information Privacy Practices, HIPPA. I give my permission for the filing of claims with my insurance company.

After receiving this vaccine we recommend you wait 15 minutes, unless otherwise identified to wait 30 minutes. If you leave the vaccination site before 15 or 30 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time. Please be aware that staff may be taking pictures for social media and clinic improvement purposes. If you do not want your picture to be taken please let us know at the clinic.

******PATIENT SIGNATURE (parent/guardian if under age 18, or is your ward)******

DATE

Whoa there. That's far enough. We'll take it from here.

VACCINE NAME	LOT NUMBER	EXPIRATION DATE	DOSE SIZE	MANUFACTURER
COVID-19			☒ **Full (1.0)** ☐ Half (0.5)	☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Pfizer
ROUTE OF ADMIN	**SITE OF INJECTION**	**DOSE IN SERIES**	**SERIES COMPLETE?**	
☒ **IM** ☐ TD ☐ IV ☐ NS ☐ SC ☐ ID ☐ O ☐ Other	☐ Left Arm ☐ Left Thigh ☐ Right Arm ☐ Right Thigh	☐ First ☐ Second	☐ Yes ☐ No	

VACCINATOR	NOTES		

CLINIC LOCATION	CLINIC TYPE	CLINIC ADDRESS	STATE VACCINE SYSTEM DATA ENTRY
			X By clinic/agency GIVING vaccine (N) ☐ By clinic/agency NOT giving vaccine (Y)

ADULT VACCINES (CIRCLE ONE)	Admin Codes (CIRCLE ONE)	CVX Code (CIRCLE ONE)	CPT Code (CIRCLE ONE)
SARS-COv-2 Vaccine			
Pfizer: mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use (2-doses required) with counseling	0001A (1st dose) 0002A (2nd dose)	208	91300
Moderna: mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use (2 doses required) with counseling	0011A (1st dose) 0012A (2nd dose)	207	91301
Janssen (Johnson & Johnson): vector-nr, rS-Ad26, preservative free, 0.5 mL dosage, for intramuscular use, (1 dose required) with counseling	0031A (1 dose)	212	91303