

Sidney-Shelby County Health Department COVID-19 Vaccine Consent Form (Please Type or Print Clearly)

FIRST NAME		MIDDLE INITIAL	LAST NAME		
DATE OF BIRTH	AGE	PHONE NUMBER		RACE <input type="checkbox"/> Alaskan Native (5) <input type="checkbox"/> American Indian (5) <input type="checkbox"/> Asian (4) <input type="checkbox"/> Black (2) <input type="checkbox"/> Native Hawaiian (7) <input type="checkbox"/> Pacific Islander (7) <input type="checkbox"/> White (1) <input type="checkbox"/> Other (6) <input type="checkbox"/> Unknown (9)	ETHNICITY <input type="checkbox"/> Hispanic/Latino (1) <input type="checkbox"/> Not Hispanic/Latino (2) <input type="checkbox"/> Unknown (3) SEX <input type="checkbox"/> Female (F) <input type="checkbox"/> Male (M) <input type="checkbox"/> Other (O) <input type="checkbox"/> Unknown (U)
EMAIL					
STREET ADDRESS					
CITY		STATE	ZIP	COUNTY OF RESIDENCE	

PATIENT QUESTIONS – ANSWER THE DAY OF VACCINATION

Have you had any type of vaccine in the last two weeks?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you ever had a severe allergic reaction to a vaccine in the past?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have a history of Guillain-Barre Syndrome?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you ever tested positive for COVID-19?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are you sick today?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have any serious health conditions (often called co-morbidities)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Is this your first or second dose in the last month?	<input type="checkbox"/> First dose	<input type="checkbox"/> Second dose

What group are you in? (select only one) <input type="checkbox"/> Assisted Living Facility Resident (TVP1) <input type="checkbox"/> Assisted Living Facility Staff (TVP2) <input type="checkbox"/> Skilled Nursing Facility Resident (TVP3) <input type="checkbox"/> Skilled Nursing Facility Staff (TVP4) <input type="checkbox"/> State of Ohio DODD Resident (TVP5) <input type="checkbox"/> State of Ohio DODD Staff (TVP6) <input type="checkbox"/> State of Ohio Veterans Home Resident (TVP7) <input type="checkbox"/> State of Ohio Veterans Home Staff (TVP8) <input type="checkbox"/> State of Ohio MHAS Resident (TVP9) <input type="checkbox"/> State of Ohio MHAS Staff (TVP10) <input type="checkbox"/> State of Ohio DRC LTC Resident (TVP11) <input type="checkbox"/> State of Ohio DRC LTC Staff (TVP12)	<input type="checkbox"/> Congregate Care Facility Resident (TVP13) <input type="checkbox"/> Congregate Care Facility Staff (TVP14) <input type="checkbox"/> Hospital worker Clinical Staff (TVP15) <input type="checkbox"/> Hospital worker Administrative Staff (TVP16) <input type="checkbox"/> Hospital worker Ancillary Staff (TVP17) <input type="checkbox"/> Non-Hospital healthcare worker Clinical Staff (TVP18) <input type="checkbox"/> Non-Hospital healthcare worker Administrative Staff (TVP19) <input type="checkbox"/> Non-Hospital healthcare worker Ancillary Staff (TVP20) <input type="checkbox"/> Emergency Medical Services EMTs/Paramedics (TVP21) <input type="checkbox"/> Age 65+ <input type="checkbox"/> Severe, Congenital Developmental or Early-Onset Medical Disorder <input type="checkbox"/> K-12 Teacher or School Staff	First dose manufacturer _____
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I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 Vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian). **I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.** I give permission to the Sidney-Shelby County Health Department to release/receive the immunization records of the above name client to any doctor, school and/or agency when requested. I also acknowledge receipt of the Sidney-Shelby County Health Department's Notice of Health Information Privacy Practices.

PATIENT SIGNATURE (or parent/guardian if patient is age 17 or under)	DATE
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STAFF USE ONLY

VACCINE NAME COVID-19		LOT NUMBER		MANUFACTURER <input type="checkbox"/> Pfizer (PFR) <input type="checkbox"/> Johnson & Johnson (JNJ) <input type="checkbox"/> Moderna (MOD) <input type="checkbox"/> Merck <input type="checkbox"/> AstraZeneca (ASZ) <input type="checkbox"/> Novavax <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> Sanofi	
ROUTE OF ADMIN <input checked="" type="checkbox"/> IM <input type="checkbox"/> TD <input type="checkbox"/> IV <input type="checkbox"/> NS <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> O <input type="checkbox"/> Oth	SITE OF INJECTION <input type="checkbox"/> RA <input type="checkbox"/> RD <input type="checkbox"/> RT <input type="checkbox"/> Other <input type="checkbox"/> LA <input type="checkbox"/> LD <input type="checkbox"/> LT _____	DOSE IN SERIES <input type="checkbox"/> First <input type="checkbox"/> Second	SERIES COMPLETE? <input type="checkbox"/> Yes <input type="checkbox"/> No		
VACCINATOR	DATE OF VACCINE	TIME	NOTES		
CLINIC LOCATION	CLINIC TYPE	CLINIC ADDRESS	STATE VACCINE SYSTEM DATA ENTRY <input type="checkbox"/> By clinic/agency GIVING vaccine (N) <input type="checkbox"/> By clinic/agency NOT giving vaccine (Y)		

Bring Form Day of Appointment