



# COVID – 19 VACCINE CONSENT FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County Where you live: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_ Gender  Male  Female

Primary Care Physician: \_\_\_\_\_

Race: Circle one    White    Black/African American    Asian    Other    American Indian/Alaska Native

Ethnicity: Circle one    Hispanic    Non-Hispanic    Not specified

- |   |       |       |
|---|-------|-------|
| 1. Has the person getting vaccinated experienced difficulty breathing or severe allergic reactions from a previous injected medication?                                   | Yes   | No    |
| 2. Has the person getting vaccinated received any other vaccines in the past 14 days?   | _____ | _____ |
| 3. Has the person getting vaccinated received a previous dose of COVID-19 vaccine? If you have which product? _____Pfizer _____Moderna    Date of previous vaccine: _____ | _____ | _____ |
| 4. Has the person getting vaccinated received monoclonal antibodies or convalescent plasma for the treatment of COVID 19 within the past 90 days?                         | _____ | _____ |
| 5. Is the person getting vaccinated currently sick with a fever, active respiratory illness, or other illness?  | _____ | _____ |
| 6. Is the person getting vaccinated currently pregnant, trying to get pregnant, or breastfeeding?   | _____ | _____ |
| 7. Does the person getting vaccinated have a history of seizures; Guillian Barre, or nervous system disorder?   | _____ | _____ |
| 8. Is the person getting vaccinated immunocompromised or taking any medication such as steroids?  | _____ | _____ |

**Patient/Guardian's Consent:** By my signature below, I affirm the information provided on this form is accurate and complete to the best of my knowledge. I give permission for myself/my child listed above to receive the EUA COVID-19 Vaccine. I understand that after the vaccine is given, I have been advised to wait on-site for 15 minutes (30 minutes for persons with allergy history) under the supervision of a medical professional. I reviewed the HCGHD Notice of Privacy Practices (HIPPA). I was given the opportunity to ask questions about EUACOVID-19 vaccine and a copy of the "Federal Emergency Use Authorization (EUA) Fact Sheet for Recipient and Caregivers" was given to me. I have received information about the V-safe program. I understand that all immunizations are reported in the Ohio State Immunization Registry. I understand that this agreement will remain in effect for the duration of time that HCHGDis able to provide the COVID-19 Vaccine and ask that the vaccine indicated on this form be given to myself/child listed above, by the Holmes County General Health District.

Patient/Guardian/Responsible Party's Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Holmes County Health District Use Only**

Vaccine Manufacturer: MOD PFIZ J&J    Vaccine Lot Number \_\_\_\_\_    Expiration Date \_\_\_\_\_

Clinic Site \_\_\_\_\_    Administration Site: \_\_\_\_\_RD \_\_\_\_\_LD \_\_\_\_\_LT \_\_\_\_\_RT (all intramuscular)

Administrator's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Observation Start Time: \_\_\_\_\_ Observation End Time: \_\_\_\_\_

Adverse Reaction Observed?  No  Yes; If yes list reaction observed:

Patient/Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Medical Professional's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Population/Occupation Data Checklist for COVID-19 Vaccine Recipients

**Purpose:** This checklist will be used to collect population and occupation information for COVID-19 vaccine recipients.

### SECTION 1: INFORMATION ABOUT VACCINE RECIPIENT (PLEASE PRINT)

|                                 |         |        |        |
|---------------------------------|---------|--------|--------|
| <b>VACCINE RECIPIENT'S NAME</b> | (First) | (M.I.) | (Last) |
| <b>DATE OF BIRTH</b>            | (Month) | (Day)  | (Year) |

### SECTION 2: INFORMATION ABOUT POPULATION AND/OR OCCUPATION

**Instructions:** Please check only one box in the section below. Please select the primary reason you are receiving the COVID-19 vaccine.

#### TARGET POPULATION/OCCUPATION

##### Phase 1A

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

##### Phase 1A (Continued)

- Non-Hospital healthcare worker – Ancillary Staff
- Non-Hospital healthcare worker – Clinical Staff
- Emergency Medical Services (EMTs/Paramedics)

##### Phase 1B

- Individuals over 80 years of age
- Individuals age 75 to 79 years of age
- Individuals age 70 to 74 years of age
- Individuals age 65 to 69 years of age
- Individuals with Congenital Disorders or Early Onset Conditions with IDD
- Individuals working in K-12 schools
- Individuals with Congenital Disorders or Early in Life Conditions that Carried into Adulthood without IDD

##### Phase 1C

- Diabetes Type 1
- Pregnant
- Bone Marrow Transplant Recipients
- ALS
- Childcare Services Worker
- Funeral Services Worker
- Law Enforcement, Corrections, Firefighter

##### Phase 1D

- Diabetes Type 2
- End Stage Renal Disease

##### Phase 1E

- Cancer
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Heart Disease
- Obesity

##### Phase 2A

- Individuals age 60 to 64 years of age

##### Phase 2B

- Individuals age 50 to 59 years of age

##### Phase 2C

- Individuals age 40 to 49 years of age

##### Phase 2D

- Individuals age 16 to 39 years of age