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		
Mother's Name (if minor) / **Father's Name (if minor)**				

Please answer the following questions to the best of your knowledge:	Yes	No	Don't Know
1. Are you a male between 12-39 years of age?	□	□	□
2. Are feeling sick today?	□	□	□
3. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine (circle one) Moderna, Pfizer, Janssen (Johnson & Johnson), Another Product _____	□	□	□
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely compromised?	□	□	□
5. Have you received a hematopoietic cell transport (HCT) or CAR-T-cell therapy since receiving the COVID-19 vaccine?	□	□	□
6. Have you ever had a severe allergic reaction* to any of the following: (*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.)			
• **To a previous dose of COVID-19 vaccine?**	□	□	□
• **To 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?	□	□	□
7. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or another injectable medication?	□	□	□
• **Have you ever had a severe allergic reaction to something <u>other than</u> injectable medications, such as food, pet, venom, environmental or oral medication allergies?**	□	□	□

8. Check all that apply to you:

□	I have a history of myocarditis or pericarditis
□	I was diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A)
□	I have a history of Heparin-induced thrombocytopenia (HIT) or thrombocytopenia syndrome (TTS)
□	I have a history of Guillain-Barre' Syndrome (GBS)
□	I've had COVID-19 DISEASE in the past 3 months
□	I have a bleeding disorder or take a blood thinner
□	I am currently pregnant or breastfeeding

If you are receiving an **ADDITIONAL / BOOSTER DOSE** today**:**

Have you consulted with your doctor regarding your need for an additional dose of COVID-19 vaccine?		Yes □	No □
What dates were your original COVID-19 vaccines given?	1st Dose:	2nd Dose:	
When was your last dose of COVID-19 vaccine or booster?	Date:		

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

Additional notes:

9/15/2022

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

□	Individuals 80 years of age or over (TPV80)	□	Individuals age 75 to 79 years of age (TPV75)	□	Individuals age 70 to 74 years of age (TPV70)
□	Individuals age 65 to 69 years of age (TPV65)	□	Individuals age 60 to 64 years of age (TPV 60)	□	Individuals age 50 to 59 years of age (TPV50)
□	Individuals age 40 to 49 years of age (TPV40)	□	Individuals age 12 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

Dosage	Vaccine/EUA Fact Sheet	Date Given	Manufacturer	Lot#	Injection Site	Administrator
0.5ml	COVID-19 Monovalent /		MODERNA		LT RT LD RD	
0.5 ml	COVID-19 Bivalent Booster/		MODERNA		LT RT LD RD	