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

FIRST NAME	MIDDLE INITIAL	LAST NAME

DATE OF BIRTH	AGE	PHONE NUMBER

EMAIL

STREET ADDRESS

RACE
- ☐ Alaskan Native (5)
- ☐ American Indian (5)
- ☐ Asian (4)
- ☐ Black (2)
- ☐ Native Hawaiian (7)
- ☐ Pacific Islander (7)
- ☐ White (1)
- ☐ Other (6)
- ☐ Unknown (9)

ETHNICITY
- ☐ Hispanic/Latino (1)
- ☐ Not Hispanic/Latino (2)
- ☐ Unknown (3)

SEX
- ☐ Female (F)
- ☐ Male (M)
- ☐ Other (O)
- ☐ Unknown (U)

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?	☐ No	☐ Yes
Have you ever had a severe allergic reaction to a vaccine in the past?	☐ No	☐ Yes
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last three months?	☐ No	☐ Yes
Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	☐ No	☐ Yes
Have you ever tested positive for COVID-19?	☐ No	☐ Yes
Are you sick today?	☐ No	☐ Yes
Do you have any serious health conditions (often called co-morbidities)?	☐ No	☐ Yes
Is this your first or second dose in the last month?	☐ First dose	☐ Second dose

First dose manufacturer _____

What group are you in? (select only one)

- ☐ Assisted Living Facility Resident (TPV1)
- ☐ Assisted Living Facility Staff (TPV2)
- ☐ Skilled Nursing Facility Resident (TPV3)
- ☐ Skilled Nursing Facility Staff (TPV4)
- ☐ State of Ohio DODD Resident (TPV5)
- ☐ State of Ohio DODD Staff (TPV6)
- ☐ State of Ohio Veterans Home Resident (TPV7)
- ☐ State of Ohio Veterans Home Staff (TPV8)
- ☐ State of Ohio MHAS Resident (TPV9)
- ☐ State of Ohio MHAS Staff (TPV10)
- ☐ State of Ohio DRC LTC Resident (TPV11)
- ☐ State of Ohio DRC LTC Staff (TPV12)
- ☐ Congregate Care Facility Resident (TPV13)
- ☐ Congregate Care Facility Staff (TPV14)
- ☐ Hospital worker Clinical Staff (TPV15)
- ☐ Hospital worker Administrative Staff (TPV16)
- ☐ Hospital worker Ancillary Staff (TPV17)
- ☐ Non-Hospital healthcare worker Clinical Staff (TPV18)
- ☐ Non-Hospital healthcare worker Administrative Staff (TPV19)
- ☐ Non-Hospital healthcare worker Ancillary Staff (TPV20)
- ☐ Emergency Medical Services EMTs/Paramedics (TPV21)
- ☐ End Stage Renal Disease (TPV33)
- ☐ Diabetes Type 2 (TPV32)
- ☐ Individuals with congenital disorders or early onset conditions with IDD (TPV22)
- ☐ Cancer (TPV34)
- ☐ Chronic Obstructive Pulmondary Disease (TPV36)
- ☐ Individuals working in K-12 schools (TPV23)
- ☐ Individuals with Congenital Disorders or Early in in life Conditions that Carried into Adulthood with IDD (TPV24)
- ☐ Diabetes Type 1 (TPV25)
- ☐ Pregnant (TPV26)
- ☐ Bone Marrow Transplant Recipient (TPV27)
- ☐ ALS (TPV28)
- ☐ Childcare Services Worker (TPV29)
- ☐ Funeral Services Worker (TPV30)
- ☐ Law Enforcement, Corrections, Firefighter (TPV31)
- ☐ Heart Disease (TPV37)
- ☐ Obesity (TPV38)
- ☐ Individuals 18+ Years of Age
- ☐ Individuals 12+ Years of Age

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

STAFF USE ONLY

VACCINE NAME	LOT NUMBER
COVID-19	

MANUFACTURER
- ☐ Pfizer (PFR)
- ☐ Johnson & Johnson (JNJ)
- ☐ Moderna (MOD)
- ☐ Merck
- ☐ AstraZeneca (ASZ)
- ☐ Novavax
- ☐ GlaxoSmithKline
- ☐ Sanofi

ROUTE OF ADMIN	SITE OF INJECTION	DOSE IN SERIES	SERIES COMPLETE?
☒ IM ☐ TD ☐ IV ☐ NS ☐ SC ☐ ID ☐ O ☐ Oth	☐ RA ☐ RD ☐ RT ☐ Other ☐ LA ☐ LD ☐ LT _____	☐ First ☐ Second ☐ Third ☐ Booster	☐ Yes ☐ No

VACCINATOR	DATE OF VACCINE	TIME

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