



ASHLAND COUNTY HEALTH DEPARTMENT

1763 STATE ROUTE 60 * ASHLAND, OHIO 44805 * 419-282-4357

Social Security Number: **Write Below**
- -

VACCINATION ADMINISTRATION RECORD

Name:		Birthdate:		Age:	Sex:
Address:			City:	Race:	
State:	Zip:	Phone:	Ethnicity: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic <input type="radio"/> Not Specified		

PLEASE ANSWER THE FOLLOWING QUESTIONS:	YES	NO
1. Are you feeling sick today?		
2. Do you have dermal fillers?		
3. Have you ever received a dose of COVID-19 vaccine? Which? <input type="radio"/> Pfizer <input type="radio"/> Moderna <input type="radio"/> Other		
4. Have you ever had an allergic reaction to: <i>(This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with an Epi pen or that caused you to go to the hospital/ER within 4 hours causing hives, swelling, respiratory distress, including wheezing)?</i>	--	--
1. A component of the COVID-19 vaccine including polyethylene glycol (PEG), which is found in some medications, such as laxative and preparations for colonoscopy procedures		
2. Polysorbate		
3. A previous dose of COVID-19 vaccine.		
5. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine or an injectable medication)?		
6. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.		
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs?		
8. Have you ever had a positive test for COVID-19 or has a doctor told you that you had COVID-19? Date: _____		
9. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? Date: _____		
10. Do you have a bleeding disorder or are you taking a blood thinner?		
11. Are you pregnant or breastfeeding?		
Select the most appropriate Target Population/Occupation code on the backside		

PLACE A CHECK OR INITIAL BESIDE EACH OF THE FOLLOWING STATEMENTS:

- _____ I have received and read, or had explained to me, the Vaccine Information Statement (VIS), including the benefits and risks. My questions have been answered to my satisfaction.
- _____ I request that this vaccine be given to me or to the person named above for whom I am guardian.
- _____ I grant permission for release of this record as necessary to my medical provider, other health departments, Ohio Department of Health, and the state immunization registry.
- _____ I Declare I Do Not Have Insurance

Signature: _____ Date: _____

Office Use:

Clinic Site:	Injection Site:	LD	RD	Route:	IM	SQ	
Date:	Name of vaccine: COVID 19	Dosage:		0.2 ml	0.25 ml	0.3 ml	0.5 ml
	Dose #1	Dose #2	Dose #3	Lot #			
Clerk Initial:	Booster Dose			Manufacturer			
	Date of Dose #1:			Vaccinator Signature:			
	Date of Dose #2:						

PLEASE CHECK ANY & ALL TARGET POPULATION OCCUPATION CODES THAT APPLY :

	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 Resident
	State of Ohio DRC LTC Staff
	Congregate Care Facility-Resident
	Congregate Care Facility-Staff
	Hospital Worker- Clinical Staff
	Hospital Worker- Administrative Staff
	Hospital Worker-Ancillary Staff
	Non-Hospital Worker-Administrative Staff
	Non-Hospital Worker-Ancillary Staff
	Non-Hospital Worker-Clinical Staff
	Emergency Medical Services (EMT/Paramedics)
	Individuals with Congenital Disorders or Early Onset Conditions with IDD
	Individuals with Congenital Disorders or Early in Life Conditions that Carried into Adulthood without IDD
	Diabetes Type 1
	Diabetes Type 2
	Pregnant
	Bone Marrow Transplant Recipients
	End Stage Renal Disease
	ALS
	Childcare Services Worker
	Funeral Services Worker
	Law Enforcement, Corrections, Firefighter
	Individual with Immunocompromised Condition
	Individual working in K-12 schools
	Individual 5-11 years of age
	Individual 12-39 years of age
	Individual 40-49 years of age
	Individual 50-59 years of age
	Individual 60-64 years of age
	Individual 65-69 years of age
	Individual 70-74 years of age
	Individual 75-79 years of age
	Individual over 80 years of age
	Cancer
	Chronic Kidney Disease
	Chronic Obstructive Pulmonary Disease
	Heart Disease