Ashland County Health Department

Public Health
Prevent. Promote. Protect.

1211 Claremont Avenue
Ashland, OH 44805
419-282-4357

Social Security Number:
Write Below
- -

COVID VACCINATION ADMINISTRATION RECORD

Name:	Birthdate:	Age:	Sex: M F Other _____
Address:	City:		Race:
State:	Zip:	Phone:	Ethnicity: ○ Hispanic ○ Non-Hispanic ○ 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? ○ Pfizer ○ Janssen ○ Moderna ○ Novavax		
4. Have you ever had an allergic reaction to: (*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)?*		
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. Do you have a history of Myocarditis or Pericarditis?		
10. Do you have a bleeding disorder or are you taking a blood thinner?		
11. Are you pregnant or breastfeeding?		

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.

Signature: _____ Date: _____

Office Use:

Clinic Site:	Injection Site:	LD	RD	LT	RT	Route:	IM			
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:	Date of Dose #5:					Vaccinator Signature:				
Date of Dose #2:	Date of Dose #6:									
Date of Dose #3:	Date of Dose #7:									
Date of Dose #4:	Date of Dose #8:									