



# ASHLAND COUNTY HEALTH DEPARTMENT

1763 STATE ROUTE 60 \* ASHLAND, OHIO 44805 \* 419-282-435

## VACCINATION ADMINISTRATION RECORD

FOR COVID-19 VACCINE

updated 15 January 2021

Name:		Birthdate:		Age:	Sex:	
Address:			City:			
State:	Zip:	Phone:				
<b>PLEASE ANSWER THE FOLLOWING QUESTIONS:</b>					<b>YES</b>	<b>NO</b>
<b>Are you feeling sick today?</b>						
Have you ever received a dose of COVID-19 vaccine? Which? Pfizer <input type="radio"/> Moderna <input type="radio"/> Other <input type="radio"/>						
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>						
<ul style="list-style-type: none"> <li>• 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</li> <li>• Polysorbate</li> <li>• A previous dose of COVID-19 vaccine</li> </ul>						
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine or an injectable medication)?						
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.						
Have you received any vaccines in the last 14 days?						
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs?						
Have you ever had a positive test for COVID-19 or has a doctor told you that you had COVID-19?						
Have you received passive antibody therapy <i>(monoclonal antibodies or convalescent serum)</i> as treatment for COVID-19?						
Do you have a bleeding disorder or are you taking a blood thinner?						
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	Route	IM	SQ
Date :		Name of vaccine:			Dose	0.25 ml	0.5 ml	
		Dose #1	Dose #2		Lot #			
Amt Paid \$_____	Unable to Pay	Company :			Manufacturer			
Cash	Check # _____	Receipt # _____	Insurance :			Nurse signature RN		
Clerk initial :		Ins #			Group #			



## ASHLAND COUNTY HEALTH DEPARTMENT

*This form is only for people who live or work in Ashland County, Ohio*

### Phase 1A includes people who provide hands-on care in these occupations:

- Staff providing direct care at congregate living centers, such as: long term care facilities, residential living centers, group homes.
- Dental Providers – treating patients
- Emergency Medical Service
- Federally qualified health center (*Emergency department, Urgent care, Pharmacy, Dialysis center*)
- Home health / Hospice
- OB-GYNs
- Primary care practitioner -- Family medicine, General medicine
- Public health
- Surgeons

**\* If you do not give direct hands-on care in these occupation sectors, it's not your turn to be vaccinated (For example: Office manager, Administrator, Clerical staff).**

### Phase 1B -COVID-19 vaccine: I'm 65+ or live with severe congenital,developmental, or early-onset medical disorder

- 80+ years of age
- 79-75 years of age
- 74-70 years of age
- 69-65 years of age
- I am diagnosed with a severe congenital, developmental, or early-onset medical disorder  
*Cerebral palsy; spina bifida; congenital heart disease, Type I diabetes, inherited metabolic disorders; severe neurological disorders including epilepsy; severe genetic disorders, including Down syndrome, fragile X syndrome, Prader-Willi syndrome, and Turner syndrome; severe lung disease including cystic fibrosis and severe asthma; sickle cell anemia; and alpha and beta thalassemia*

***Please register with the Ashland County Health Department at:  
[www.ashlandhealth.com](http://www.ashlandhealth.com) and complete the Covid-19 request form***

**You will be contacted by phone or email with a time & specific location in Ashland County for your vaccination**

***Please complete the form on the opposite of this page to help us properly register you.***