LMHS COVID Vaccine Administration Record
Community Members

FIRST NAME	MIDDLE INITIAL	LAST NAME

DATE OF BIRTH	AGE

PHONE NUMBER	EMAIL

STREET ADDRESS

RACE
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White
- ☐ Other
- ☐ Unknown

ETHNICITY
- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino
- ☐ Unknown

SEX
- ☐ Female
- ☐ Male
- ☐ Other
- ☐ Unknown

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 or any injection in the past?	☐ No	☐ Yes
Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?	☐ 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 received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?	☐ No	☐ Yes
Do you have any serious health conditions (often called co-morbidities)?	☐ No	☐ Yes
Do you have a weakened immune system (ie, from HIV or cancer) or are you on immunosuppressive drugs?	☐ No	☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No	☐ Yes
Are you pregnant or breastfeeding?	☐ No	☐ Yes
Do you feel sick today?	☐ No	☐ Yes

Is this your first or second dose in the last month? ☐ First dose ☐ Second dose

First dose manufacturer _____

First dose date _____

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 (TPV20)
- ☐ Non-Hospital healthcare worker Administrative Staff (TPV18)
- ☐ Non-Hospital healthcare worker Ancillary Staff (TPV19)
- ☐ Emergency Medical Services EMTs/Paramedics (TPV21)
- ☐ Individuals with congenital disorders or early onset conditions with IDD (TPV22)
- ☐ Individuals working in K-12 schools (TPV23)
- ☐ Individuals with Congenital Disorders or Early in Life Conditions that Carried into Adulthood without 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)
- ☐ Diabetes Type 2 (TPV32)
- ☐ End Stage Renal Disease (TPV33)
- ☐ Cancer (TPV34)
- ☐ Chronic Kidney Disease (TPV35)
- ☐ Chronic Obstructive Pulmonary Disease (TPV36)
- ☐ Heart Disease (TPV37)
- ☐ Obesity (TPV38)
- ☐ Individuals over 80 years of age (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 (TPV60)
- ☐ Individuals age 50 to 59 years of age (TPV50)
- ☐ Individuals age 40 to 49 years of age (TPV40)
- ☐ Individuals age 16 to 39 years of age (TPVALL)

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to learn about the benefits and risks (VIS) of the COVID-19 vaccine. Please visit our website (posted at the clinic) to read our Privacy Policy (PP). By signing below, you agree that 1) you reviewed both the VIS and PP, 2) you understand the benefits and risks of the vaccine and you are asking that the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby consent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record and all information on this form to your state's Immunization Program and the CDC, and 5) we can release this record to your doctor, school, or employer if requested. You understand the CDC and the Ohio Department of Health guidelines recommend that you be monitored for 15 minutes after your injection, or 30 minutes if you have had an immediate allergic reaction to any vaccine or injectable therapy or a history of anaphylaxis due to any cause. You further understand that it is your responsibility to remain in the LMHS designated area for such monitoring.

PATIENT CONSENT / SIGNATURE (or parent / guardian if applicable)	DATE OF CONSENT

To be completed by vaccine administrator in the event of EMR downtime:

DATE ADMINISTERED	VACCINE MANUFACTURER	LOT NUMBER AND EXPIRATION DATE	DOSE	SITE OF INJECTION
			1 2	R L DELTOID

PRINT NAME SIGNATURE

R.N. / L.P.N EMPLOYEE #

PATIENT TOLERATED WELL: ☐ Yes ☐ No (see note)

NOTES: _____

1951-0074 3/24/21