Shelby City
Health Department
Live Healthy. Stay Healthy.

Shelby City Health Department
COVID-19 VACCINE ADMINISTRATION RECORD

Name: First	**Middle Initial:**	**Last:**	
Date of Birth:	**Race:**	**SS#**	**Sex: Male / Female**
Address:			
City:	**State: OHIO**	**Zip:**	

PLEASE ANSWER THE FOLLOWING QUESTIONS:	**YES**	**NO**
Are you sick today?		
In the past two weeks, have you tested positive for COVID or are you currently being monitored for COVID-19? Have you received the COVID-19 vaccine? If yes, **circle** which vaccine product? Pfizer Moderna Another product _____		
In the past two weeks, have you had contact with anyone who tested positive for COVID-19?		
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
Do you currently, or have you in the past 14 days had a fever, chills, sore throat, cough, shortness of breath, new loss of taste or smell, nausea, vomiting, or diarrhea?		
Do you have any allergies to foods, medications, vaccines, or latex?		
Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly after a vaccine? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had a go to the hospital?		
Have you had a seizure, or a brain, or other nervous system problem or Guillain Barre?		
Do you take anticoagulation medication? Warfarin or coumadin or other blood thinners?		
Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease, anemia, or other blood disorder?		
Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Chron's disease or other immune system problem?		
Do you have a weakened immune system? Or in the past 3 months, taken medications that weaken it such as cortisone, prednisone, or steroids, anticancer drugs, or radiation treatments?		
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
For Women: Are you pregnant or breastfeed? Is there a change you could become pregnant during the next month?		
Have you received any vaccinations; including COVID-19 or TB skin test in the past 4 weeks?		

Have you received a copy of the COVID-19 Emergency Use Authorization (EUA) dated (12/2020)	X	
I request to receive the COVID-19 vaccine, or request the vaccine be given to the above-named individual for whom I am authorized by law to make said request.	X	

I understand that any information so released will be treated as confidential by SCHD, in accordance with SCHD's HIPAA policies and have been offered a copy of SCHD's HIPAA policy. I authorize Shelby City Health Department (SCHD) to release to the named insurance company any medical or other information required to process a claim for benefits. I understand that SCHD will accept assignment of any claim and my signature below authorizes said intermediary to pay benefits on my behalf, directly to SCHD.

Signature of person receiving vaccine or person authorized to make a request on behalf of named (parent/guardian)

X _____ **Date:** _____

Instructions: Please check only ONE box in the section below.

Please select the primary reason you are receiving the COVID-19 vaccine.

TARGET POPULATION/OCCUPATION:

- ☐ age 65 and up
- ☐ age 75 and up
- ☐ age 80 and up
- ☐ severe congenital or medical conditions
- ☐ School Teachers
- ☐ School Administrative staff
- ☐ School workers
- ☐ Student
- ☐ Mental Health and Addiction Services (MHAS) – Resident
- ☐ State of Ohio Mental Health and Addiction Services (MHAS) – Staff
- ☐ State of Ohio Dept. of Rehabilitation & Correction – LTC residents
- ☐ Other
- ☐ State of Ohio Dept. of Rehabilitation & Correction – LTC staff
- ☐ Congregate Care Facility – Resident
- ☐ Congregate Care Facility – Staff
- ☐ Hospital worker – Clinical Staff
- ☐ Hospital worker – Administrative Staff
- ☐ Hospital worker – Ancillary Staff
- ☐ Non-Hospital healthcare worker – Administrative Staff
- ☐ Non-Hospital healthcare worker – Ancillary Staff
- ☐ Non-Hospital healthcare worker – Clinical Staff
- ☐ Emergency Medical Services (EMTs/Paramedics)

TO BE COMPLETED BY SCHD STAFF ONLY:

PH NURSE USE ONLY:

Injection Site:	Vaccine Lot #:	Manufacturer:	Nurse's Signature:
LD RD LT RT	MDV PFS	Moderna	

91301	Moderna MDV	0011A	ADM SARSCOV2 – First Dose	0012A	ADM SARSCOV2 Second Dose