Cuyahoga County Board of Health
COVID VACCINE INTAKE FORM

Patient Information (please print)
Last Name: _____ First Name:_____ Middle Initial: _____ Male ____ Female ____ Email Address: _____
Phone #: __ __ __ -- __ __ __ -- __ __ __ __ Date of Birth: ___ / ___ / __ Current Age _____
Street Address: _____
City: _____ State: _____ Zip Code : _____
Your Ethnicity (please circle a response)? Hispanic / Non-Hispanic
Your Race (please circle all that apply to you)? Caucasian (White) / Black / Asian / Alaskan Native (American Indian) / Other: _____

Please answer the following questions for the person receiving the COVID vaccine today (circle yes or no):

1. Are you feeling sick today?	NO / YES
2. Have you ever received a dose of COVID vaccine in the past?	NO / YES
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	NO / YES
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	NO / YES
5. Have you received another vaccine in the last 14 days?	NO / YES
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	NO / YES
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	NO / YES
8. Do you have a bleeding disorder or are you taking a blood thinner?	NO / YES
9. Are you pregnant or breastfeeding?	NO / YES

PLEASE CIRCLE THE BEST DESCRIPTION OF YOUR EMPLOYMENT

ASSISTED LIVING FACILITY RESIDENT	HOSPITAL ANCILLARY STAFF	SKILLED NURSING FACILITY RESIDENT	STATE OF OHIO DRC LTC STAFF
ASSISTED LIVING FACILITY STAFF	HOSPITAL CLINICAL STAFF	SKILLED NURSING FACILITY STAFF	STATE OF OHIO MHAS RESIDENT
CONGREGATE CARE FACILITY RESIDENT	NONHOSPITAL HEALTHCARE ADMINISTRATIVE STAFF	STATE OF OHIO DODD RESIDENT	STATE OF OHIO MHAS STAFF
CONGREGATE CARE FACILITY STAFF	NONHOSPITAL HEALTHCARE ANCILLARY STAFF	STATE OF OHIO DODD STAFF	STATE OF OHIO VETERANS HOME RESIDENT
EMERGENCY MEDICAL SERVICES	NONHOSPITAL HEALTHCARE CLINICAL STAFF	STATE OF OHIO DRC LTC RESIDENT	STATE OF OHIO VETERANS HOME STAFF
HOSPITAL ADMINISTRATIVE STAFF			

PLEASE TURN OVER TO BACK PAGE TO COMPLETE CONSENT FORM

Clinic Use Only: Clinic Location:

Vaccine	Date Administered	Vaccine Manufacturer	Vaccine Lot number	Site Given	Signature & Title of Vaccine Administrator
COVID 19 Vaccine				L R Deltoid	

CUYAHOGA COUNTY BOARD OF HEALTH
COVID 19 IMMUNIZATION CONSENT

Consent to Healthcare Services

I am authorizing Cuyahoga County Board of Health (CCBH) to provide health services to me, my child, or the client named above. I am also aware that healthcare services often involve risk and no guarantee has been made to me about the results of treatment. If I am receiving vaccine(s), I will receive a copy and be given the chance to read (or have read to me) the information contained in the appropriate Vaccine Information Statement (or COVID 19 information equivalent issued by the CDC) about the disease(s) and vaccine(s) to be administered. I will ask questions if needed and notify staff members if I need additional information. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) recommended be given to me or the person named above for whom I am authorized to make this request.

Vaccine Data Release to State of Ohio Immunization Registry

CCBH participates in the Ohio Immunization Registry known as IMPACT SIIS. Following administration of the vaccine the visit information will be uploaded to the system. This allows state and federal health officials to track vaccine efforts and also allows other health care provider including your primary physician to view your current immunization status.

Notice of Privacy Practice/HIPAA

I acknowledge that the CCBH Privacy Notice will available at the immunization event as part of my initial registration process and that I may request a copy at that time. I can also request a copy prior to the event by emailing ccbhnurse@ccbh.net. I understand that the terms of the Privacy Notice may change and I may get these changed notices by contacting CCBH by phone or in writing. I understand I have the right to ask how my protected health information will be used and/or given out.

_____ _____

Signature of client or responsible party Date

_____ _____

Printed name of responsible party if not the client (if applicable)

Relationship to client (if applicable)

Date Revised 1/24/2021