

1st Dose Date: _____

Cuyahoga County Board of Health
COVID VACCINE INTAKE FORM

Patient Information (please print)

Last Name: _____ First Name: _____ Middle Initial: _____

Male Female Date of Birth: ____/____/____ Current Age: _____

Phone Number: (____) _____-____-____ Email Address: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Race: Caucasian (White) Black Asian Alaskan Native (American Indian)

Other: _____

Ethnicity: Hispanic Non-Hispanic Phase: 1A 1B DOSE: 1st 2nd

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

| | |
|---|--|
| 1. Are you feeling sick today? | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| 2. Have you ever received a dose of COVID vaccine in the past? | <input type="checkbox"/> NO <input type="checkbox"/> 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? | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| 4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| 5. Have you received another vaccine in the last 14 days? | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| 6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? | <input type="checkbox"/> NO <input type="checkbox"/> 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? | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| 8. Do you have a bleeding disorder or are you taking a blood thinner? | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| 9. Are you pregnant or breastfeeding? | <input type="checkbox"/> NO <input type="checkbox"/> YES |

PHASE 1A DESCRIPTION:

| | | | |
|--|---|--|---|
| <input type="checkbox"/> Assisted Living Facility Resident | <input type="checkbox"/> Assisted Living Facility Staff | <input type="checkbox"/> Hospital Ancillary Staff | <input type="checkbox"/> Hospital Clinical Staff |
| <input type="checkbox"/> Hospital Administrative Staff | <input type="checkbox"/> Skilled Nursing Facility Resident | <input type="checkbox"/> Skilled Nursing Facility Staff | <input type="checkbox"/> State of Ohio MHAS Resident |
| <input type="checkbox"/> State of Ohio MHAS Staff | <input type="checkbox"/> State of Ohio DRC LTC Resident | <input type="checkbox"/> State of Ohio DRC LTC Staff | <input type="checkbox"/> State of Ohio DODD Resident |
| <input type="checkbox"/> State of Ohio DODD Staff | <input type="checkbox"/> State of Ohio Veterans Home Resident | <input type="checkbox"/> State of Ohio Veterans Home Staff | <input type="checkbox"/> Emergency Medical Services |
| <input type="checkbox"/> Congregate Care Facility Resident | <input type="checkbox"/> Congregate Care Facility Staff | <input type="checkbox"/> Nonhospital Healthcare Clinical Staff | <input type="checkbox"/> Nonhospital Healthcare Ancillary Staff |
| <input type="checkbox"/> Nonhospital Healthcare Administrative Staff | | | |

PHASE 1B DESCRIPTION:

| | | | |
|--|---|---|--|
| <input type="checkbox"/> Individual Aged 65 to 69 | <input type="checkbox"/> Individual Aged 70 to 74 | <input type="checkbox"/> Individual Aged 75 to 79 | <input type="checkbox"/> Individual Over 80 years of Age |
| <input type="checkbox"/> Individual working in K-12 School | <input type="checkbox"/> Individual with Congenital Disorders or early onset conditions | | |

PLEASE TURN OVER TO BACK PAGE TO COMPLETE CONSENT FORM

This Section for 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)