Licking County Health Department
675 Price Rd
Newark, OH 43055
(740) 349-6535

COVID-19 Vaccine Administration Record

LEGAL First Name	M.I.	LEGAL Last Name	Date of Birth	Age	Sex
					Male ☐ Female ☐

Social Security #	Race (for statistical use only)			Hispanic?
	☐ Asian	☐ White	☐ Other:_____	☐ Yes
	☐ Black	☐ Native American		☐ No

Street Address	City	State	Zip	County

Phone	Occupation

Email	Employer

Are you sick today?	Yes ☐	No ☐
Have you been diagnosed with COVID-19 in the past 10 days?	Yes ☐	No ☐
Do you have any allergies to food, latex, medications, or vaccine?	Yes ☐	No ☐
Have you ever had a serious allergic reaction to a vaccine?	Yes ☐	No ☐
In the past 90 days, have you received a plasma infusion or monoclonal antibodies for COVID-19?	Yes ☐	No ☐
Have you received another vaccine in the last 14 days?	Yes ☐	No ☐
Have you ever had a seizure, brain or other nervous system problems?	Yes ☐	No ☐
Do you have cancer, leukemia, AIDS, or any other immune system problem?	Yes ☐	No ☐
Do you take cortisone, prednisone or other steroids or anti-cancer drugs?	Yes ☐	No ☐
Women Only: Are you pregnant or is there a chance that you could be pregnant?	Yes ☐	No ☐

I was given an explanation about COVID-19, the COVID-19 vaccine and was offered a copy of the Vaccine Information Statement (VIS). I had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risk of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I hereby consent that the Licking County Health Department (LCHD) bill my insurance, if applicable. I authorize the release of this record to the Ohio Department of Health Immunization Program. I hereby acknowledge I was offered a copy of LCHD's Notice of Health Information Privacy Practice and give my permission to release my immunization record to my doctor or workplace/school.

Signature _____ Date _____

HEALTH DEPARTMENT STAFF USE ONLY No Card? ☐ No Ins? ☐

Medicaid: Buckeye CareSource Medicaid Molina Paramount UHC COM
Medicare: Part B Aetna Anthem Humana Medigold Other:_____

Private Insurance Name: _____ Payer ID _____

Member ID: _____ Group #: _____
Name of Policy Holder: _____ DOB: _____
Policy Holder's SSN: _____ Relationship to Policy Holder: Self Spouse Child Other

☐ BG
☐ GN
☐ JH
☐ JP
☐ SJ
☐ KH
☐ KK
☐ MS
☐ MH

Site of Admin: (L) ___ / (R) ____

Date of Admin & VIS/EUA: _____