LICKING COUNTY HEALTH DEPARTMENT

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

# COVID-19 Vaccine Administration Record

**SECOND DOSE**

Has any of your demographic or insurance information changed since Dose 1? ☐ YES ☐ NO
If no, complete the outlined boxes and proceed to questions. If yes, complete all fields.

| LEGAL First Name | M.I. | LEGAL Last Name | Date of Birth |
|---|---|---|---|
| | | | |

| 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: _____