Print

# Covid 19 Vaccination Clinic Tool

Reset

Appt Date & Time:

**Section 1**

**Client's Name:** First MI Last **DOB:** **Age:**

**Phone #:** **Sex:** **Email:**

**Client's Street Address:**

**City:** **State:** OH **Zip:** **County:**

**Race:** ☐ African American ☐ Asian ☐ White ☐ Other

**Ethnicity:** ☐ Hispanic ☐ Not-Hispanic

**Parent/Guardian Name (Please Print):**

**Facility Name: Rocking Horse Center 20075** **Administration Address & County: 651 S. Limestone St, Springfield, Ohio 45505 Clark**

## Covid-19 Vaccine Consent Form

**Section 2**

- I hereby acknowledge access to or receipt of the Notice of Health Information Privacy Practices (HIPAA), and receipt of Vaccine Information Sheet (VIS)
- I have completely read the provided information about the authorized COVID-19 vaccine and I have had an opportunity to ask questions concerning the benefits and risks of the COVID-19 vaccine. I have answered all screening questions truthfully and attest to belonging to one of the target populations as documented below. I have made a personal decision to receive this vaccine. I understand that, as with all medical treatment, there is no guarantee that I will not experience an adverse side effect to the vaccine. I affirm that I will receive both dosages of the vaccine (if applicable) and I will sign up using the methods provided to me and keep my follow-up appointment.
- I give Rocking Horse Center permission to administer a COVID-19 vaccine to myself or minor child age 16-17.
- I authorize the release of my/minor's immunization record and information on this form to the Ohio Department of Health Immunization Program and the CDC
- I give consent to Rocking Horse Center to bill my insurance, if applicable.
- After receving the vaccine, I will be asked to remain in the facility for a recommended amount of time (15 or 30 minutes). If I leave before the recommended time has passed, I assume any risks associated with not waiting the recommended time.

_____ _____

Signature of Client/Parnet/Legal Guardian Date

_____ _____

Print name of Client/Parent/Legal Guardian Relationship to Client

## Target Population/Occupation: Please check ONLY one box

**Section 3**

- ◯ State of Ohio Dept of Rehabilitation & Correction LTC Staff
- ◯ Assisted Living Facility – Staff
- ◯ Skilled Nursing Facility (RCF) – Staff
- ◯ State of Ohio Veterans Home – Staff
- ◯ State of Ohio Dept. of Dev. Disabilities (DODD) – Staff
- ◯ State of Ohio Mental Health and Addiction Services (MHAS) – Staff
- ◯ State of Ohio Mental Health & Addiction Services (MHAS) – 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)
- ◯ Chronic Obstructive Pulmonary Disease (COPD)
- ◯ Heart Disease
- ◯ Obsesity
- ◯ Individuals age 16 to 39 ***Eligible as of March 29***
- ◯ Individuals over 80 years of age
- ◯ Individuals age 75 to 79 years of age
- ◯ Individuals age 70 to 74 years of age
- ◯ Individuals age 65 to 69 years of age
- ◯ Individuals with congenital disorders & early onset conditions with IDD (TPV 22) Individuals working in K-12 Schools
- ◯ Individuals with Congenital Disorders or Early In Life Conditions carried into adulthood without other intelectual disabilities. (TPV 24)
- ◯ Diabetes - Type 1
- ◯ Pregnant
- ◯ Bone Marrow Transplant Recipients
- ◯ ALS
- ◯ Childcare Services Worker
- ◯ Funeral Servicies Worker
- ◯ Law Enforcement, Corrections, Firefighter
- ◯ Individuals age 60 to 64
- ◯ Individuals age 50 to 59
- ◯ Individuals age 40 to 49
- ◯ Diabetes - Type 2
- ◯ Cancer
- ◯ Chronic Kidney Disease

Section 4

| Please answer the following Screening Questions: | |
|---|---|
| Is this your first Covid 19 Vaccine? | |
| In the past two weeks, have you tested positive for COVID 19 or are you currently being monitored for Covid19? | |
| In the past two weeks, have you had contact with anyone who tested positive for COVID 19? | |
| Do you currently or have you in the past 14 days, had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea? | |
| Are you sick today? (For example: a cold, fever, or acute illness) | |
| Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) | |
| Have you had a seizure or a brain disorder or other nervous system problem or Guillain Barre? | |
| Do you take anticoagulation medication? For example: warfarin, Coumadin or other blood thinner | |
| Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma or any other immune system problem? | |
| Do you have a weakened immune system or in past 3 months, take medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments? | |
| Has the person receiving shots received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin in the past year, taken an anti-viral drug, received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? | |
| For women: are you pregnant or is there a chance you could become pregnant during the next month? Are you breastfeeding? | |
| Have your received any vaccinations or TB skin test in the past 2 weeks? | |

Section 5_RHCHC USE ONLY

◯ 15 Minute Observation ◯ 30 Minute Observation

ID Checked: Yes **Print** **Reset** **Back to top**

Vaccine Charting

RHCHC Use ONLY: **Date:** **Giver:** _____ _____ **Documenter:** Dose: 1 2
Signature and Vaccinator Number

LOT #/Expiration Date:

CVX Code:

Manufacturer:

Site: Right Deltoid IM Left Deltoid IM Right Thigh IM Left Thigh IM