Last Updated October 2021

COVID 19 Vaccination Clinic Tool
BOOSTER or 3rd Dose

Reset Form

Section 1a- 3rd dose

1. **Are you Immunocompromised as defined by the CDC with one of these conditions?**
   - Individuals undergoing active treatment for cancer (solid tumor and hematologic malignancies).
   - Individuals who have received a solid-organ transplant and are taking immunosuppressive therapy.
   - Individuals who have received a CAR-T-cell or hematopoietic stem cell transplant (within two years of transplant or taking immunosuppression therapy).
   - Individuals with moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome).
   - Individuals with advanced or untreated HIV infection.
   - Individuals undergoing active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory.

2. **Did you receive 2 doses of Pfizer or Moderna vaccine at least 28 days ago?**

2b. Brand: ☐ Moderna ☐ Pfizer

☐ **Eligible for 3rd dose if both are "Yes"** ☐ **Not eligible for 3rd dose (check eligibility for booster)**

Section 1b- booster dose

1. **Did you complete your primary series?**

A primary series is defined as:
- **1 dose of J&J if not immunocompromised**
- **1 dose of J&J and 1 full dose of Moderna or Pfizer if mmunocompromised**
- **2 doses of Pfizer or Moderna if not immunocompromised**
- **3 doses of Pfizer or Moderna if immunocompromised**

1B. Primary Series Brand: ☐ Moderna ☐ Pfizer ☐ J&J

2. **Are you at least 12 years old?**

3. **Has it been at least 2 months since last dose if Moderna , Pfizer, and J&J?**

Date of last dose:

☐ **Eligible for booster dose if both are "Yes"** ☐ **Not eligible for booster dose (check back later)**

Section 2- prior dose

Will you be able to bring your vaccination card or other documentation to your appointment with us?

Are you currently suspected or confirmed to have COVID-19 or are currently advised to quarantine due to possible/confirmed exposure. (If yes, please schedule appt when you are out of quarantine)

Location Received (Example RHC, Health Dept., etc) :

Appt Date and Time:

Section 3

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

Print

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Section 4

Covid-19 Vaccine Consent Form

- I hereby acknowledge access to or receipt of the Notice of Health Information PrivacyPractices (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. 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.
- 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 receiving 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/Parent/Legal Guardian _____ Date _____

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

Section 5

Please answer the following Screening Questions:

1. Are you sick today? (for example: a cold, fever, or acute illness)	
2. Have you had COVID-19 and was treated with monoclonal antibodies or convalescent serum. **2B. Date if yes:**	
3. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) **3B. Describe if yes:**	
4. Do you have a history of myocarditis (an inflammation of the heart muscle or pericarditis (swelling and irritation of the thin, saclike tissue surrounding your heart)?	
5. Do you have a bleeding disorder or take anticoagulation medication? For example: warfarin, Coumadin or other blood thinner.	
6. Diagnosed with Multisystem Inflammatory Syndrome; either MIS-C (children) or MIS-A (adults) after a COVID-19 infection. a condition where different body parts can become inflamed, including the heart, lungs, kidneys, brain, skin, eyes, or gastrointestinal organs	
7. Had dermal fillers? (injectable implants, soft tissue fillers, or wrinkle fillers)	

Additional questions if receiving Pfizer or Moderna (mRNA vaccines)

1. Males between 12-29 years of age	

Reset Form ○ 15 Minute Observation ○ 30 Minute Observation Print

Section 6 RHCHC USE ONLY

ID Checked: Yes

Vaccine Charting

RHCHC Use ONLY: **Date:** **Giver:** _____ (Signature and Vaccinator Number) **Dose:** Booster / 3rd dose

LOT #/Expiration Date:

CVX Code:

Manufacturer:

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

Injection Volume: 0.2 mL 0.25 mL 0.3 mL 0.5 mL