Clermont County Public Health
Prevent. Promote. Protect.

COVID-19 Vaccine Registration Form

Please fill out to the black line

Patient Information

First Name	Middle Initial	Last Name	Race	Ethnicity
			☐ American Indian Or Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black Or African American ☐ White ☐ Other Race	☐ Hispanic ☐ Not Hispanic Or Latino ☐ Unknown ☐ Decline to answer

Date Of Birth	Age	17 Or Under?	Phone Number OK To Text?
_____/_____/_____		Y N	(_____) _____-_____

County Of Residence	Email OK To Email?
	Y N

Street Address	City	State	Zip

Patient Questionnaire

PREVACCINATION CHECKLIST

Are you feeling sick today?	☐ No ☐ Yes
Have you ever had a serious reaction to any food medication or vaccine?	☐ No ☐ Yes
Do you have a history of fainting, particularly with vaccines?	☐ No ☐ Yes
Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? (such as treatment for cancer, or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T cell therapy, hematopoietic cell transplant (HCT), DiGeorge syndrome or Wiskott-Aldrich syndrome)	☐ No ☐ Yes
How many doses of COVID vaccine (any type) have you already received?	☐ 0 ☐ 1 ☐ 2 ☐ 3

Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Have a history of Guillain-Barre Syndrome (GBS)
- ☐ Seizures
- ☐ Other medical condition

Please visit the CDC website https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html to read the vaccine frequently asked questions (FAQ) and or Vaccine Information Sheet (VIS) for the COVID-19 vaccine. Please visit our website www.ccphohio.org to read the Privacy Policy (PP). By signing below, you agree that 1) you were given the opportunity to review the vaccine FAQ and or VIS and PP, 2) you understand the benefits and risks of the vaccine and you are asking that the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby consent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record to your state's Immunization Program and the CDC, and 5) we can release your immunization record to your doctor or school if requested. If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient and the patient on this form may receive vaccine with or without you, as the parent or guardian, present at the time of vaccination. After receiving your vaccine we recommend you wait at the vaccination site for 15 to 30 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time.

PATIENT SIGNATURE (or parent/guardian if patient is age 17 or under)	**DATE** _____/_____/_____

Whoa there, that's far enough. The vaccinator will take it from here.

Vaccine Name	Lot Number	Expiration Date	Dose Size	Manufacturer
Covid-19		_____/_____/_____	mL	☐ Pfizer ☐ Johnson & Johnson ☐ Moderna

Route Of Admin	Site of Injection	Dose In Series	Series Complete?
☐ IM ☐ Other _____	☐ Left Arm ☐ Right Arm	☐ 1st ☐ 2nd ☐ Booster	☐ Y ☐ No

Clinic Location	Other Clinic Location	Impact Data Entry Complete
		Date _____/_____/_____ Initial _____

VACCINATOR	DATE	NOTES:	Rev: 3/09/22