Summit County Public Health

INJECTABLE

NAME: Last Name, First Name		DATE OF BIRTH	AGE	SEX
ADDRESS: Number and Street	CITY	STATE / ZIP CODE		PHONE NUMBER
RACE		ETHNICITY		
POPULATION / OCCUPATION		EMPLOYER		EMAIL

CONSENT

I hereby give my consent for the physicians and staff of Summit County Public Health to examine, give medical care/treatment and perform diagnostic therapeutic procedures and to administer such medications/vaccines as may be necessary and appropriate to the patient named above. If receiving immunizations, I have been provided a copy of and have read the *Fact Sheet for Recipients and Caregivers: Emergency Use Authorization (EUA) of The Moderna, Pfizer, or Johnson and Johnson COVID-19 Vaccine to Prevent Coronavirus Disease 2019 in Individuals 18 Years of Age and Older* for the Moderna, Pfizer, or Johnson and Johnson COVID-19 vaccine. The immunization dates will be sent to the Ohio Department of Health and entered in the state vaccine registry. I have received and reviewed the District's Notice of Privacy Practices and understand that these explain how the medical information of the patient may be used and disclosed. I acknowledge that this consent is voluntary and I may revoke the consent orally, in writing to the Health District Privacy Officer at 1867 West Market Street, Akron OH 44313, or by emailing hipaa@schd.org. I authorize the release of any information concerning my (or my child's) health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits. We may disclose health information to doctors or hospitals that are treating you. We may also use your health information to arrange certain services for you or to refer you to another program within the Department of Health. If payment is required, I also hereby authorize payment of insurance benefits otherwise payable to me directly to Summit County Public Health. Fact Sheet for Recipients and Caregivers: 12/2020.

SIGNATURE (Self, Parent, Guardian) : **DATE:**

FOR CLINIC/OFFICE USE ONLY.

NOTES:

VACCINE INFO	**SITE OF INJECTION**
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CPT	**TAX ID** 34-6002767 **NPI** 1801939814 **Medicare PIN** FV90251

ADMIN CODES	ICD-10	DATE	CLINIC SITE
Medicare Admin. G0008 Admin. 90471F	Z23		SCPH

Photo ID Presented and Reviewed Name on Health Insurance Card Matches Photo ID

Staff Name:

Signature/Title of Vaccine Administrator:

revised: 03-09-2021

Pre Vaccination Checklist	NO	Don't Know	YES
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
● If yes, which vaccine product?			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
● A component of a COVID-19 vaccine including either of the following:			
❏ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
❏ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
● A previous dose of COVID-19 vaccine.			
● A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received another vaccine in the last 14 days?			
7. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			
SIGNATURE (Self, Parent, Guardian) :	**DATE:**		