Clinic:_____ Today's Date: _____

# COVID-19 Vaccination Form

Please complete each field below with the information that applies to the client receiving services today.

| CLIENT INFORMATION | | | | | |
|---|---|---|---|---|---|
| **Name** (Last, First, MI) _____, _____, | | **Suffix (eg., Jr, III)** | | **Date of Birth** | **Age†** |
| **Street Address** | | **City** | **State** | **Zip** | **County** |
| **Phone Number** ☐ Cell ☐ Home ( ) | **Sex** ☐ Female ☐ Male ☐ Other ☐ Unknown | **Race** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other | | **Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown | |

**If the client is under 18 years of age, please complete guardian information.**
**Guardian relationship to client:** ☐ Father ☐ Mother ☐ Legal Guardian ☐ Other **Guardian Name (Last, First)** _____, _____, ___

## CONSENT FOR SERVICE

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma State Department of Health (OSDH) and its entities/contractors. I understand that:

-- the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions.
-- the information regarding myself and the services I receive will be entered into OSDH management information systems and may be used for program evaluation, management, and billing purposes.
-- I may refuse service at any time.

I acknowledge that I have received a copy of the Oklahoma State Department of Health Privacy Statement as required by the Health Information Portability and Accountability Act (HIPAA). I can also find a copy on the agency website. I also acknowledge that I received the manufacturer-specific Fact Sheet for Recipients and Caregivers prior to receiving the vaccine.

Client/Guardian Signature: _____ Date: _____

†Client must be aged 16 years or older to receive the vaccine.

****FOR OSDH USE ONLY****

Client Name (Last, First, MI) _____,_____,___ Client DOB (MM/DD/YYYY)_____

| *OFFICE USE ONLY – DO NOT WRITE BELOW* | | | | | | |
|---|---|---|---|---|---|---|
| Client completed the manufacturer's screening questions: ☐ Y ☐ N | | | | | | |
| Vaccine Manufacturer: | **Pfizer-BioNTech** | **Moderna** | **Moderna** | Site:<br>☐ LT DELTOID IM<br>☐ RT DELTOID IM<br>☐ LT VAST LAT IM<br>☐ RT VAST LAT IM | EUA*/VIS given? ☐ Y ☐ N<br>Reaction? ☐ Y ☐ N | Dose Number:<br>☐ 1st ☐ 2nd |
| Lot #: | EH9899 | 011J20A | 025J20-2A | | | |
| Exp. Date: | 3/2021 | May 11 2021 | Feb 25 2021 | | | |
| Vaccination Complete? ☐Complete ☐Refused ☐Not administered ☐Partially administered ☐No recorded completion status | | | | | | |
| Provider Signature: | | | | | | |

*EAU = Emergency Use Agreement

Progress Note:_____

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