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 at birth** ☐ Female ☐ Male	**Gender Identity** ☐ Female ☐ Male ☐Non-binary ☐ Unknown ☐ Prefer not to say
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

I understand that the COVID-19 vaccine is a voluntary vaccine currently being given under the Emergency Use Authorization status and only a parent or legal guardian has the authority to consent to a minor receiving this vaccine. By signing this form I certify that I have the legal authority to do so on behalf of the patient identified above and will indemnify Oklahoma City-County Health Department against challenges to this consent or my status as legally able to provide consent for this vaccine.

Guardian Printed Name (Last, First) ____,____,___

State or Federally issued ID # ___________________________________

CONSENT FOR SERVICE

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma City-County Health Department (OCCHD) 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 OCCHD 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 City-County Health Department HIPAA Privacy Notice 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 12 years or older to receive the Pfizer vaccine and aged 18 years or older to receive the Moderna or Johnson & Johnson vaccine.

****FOR OFFICIAL 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: Lot #: Exp. Date:	Site: ☐ LT DELTOID IM ☐ RT DELTOID IM ☐ LT VAST LAT IM ☐ RT VAST LAT IM	EUA*/VIS given? ☐ Y ☐ N Reaction? ☐ Y ☐ N	Dose Number: ☐ 1st ☐ 2nd

Vaccination Complete? ☐Complete ☐Refused ☐Not administered ☐Partially administered ☐No recorded completion status

Provider Signature:

*EAU = Emergency Use Agreement

Progress Note:____

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