Pike County General Health District

Public Health Division
116 S. Market Street
Waverly, Ohio 45690
Phone 740-947-7721 Fax 740-947-1109 mminor@pike-health.org

Person Receiving Vaccine Demographic Information

Last Name	First Name	Middle Name
Date of Birth	Age	Township
Sex ☐ Male ☐ Female ☐ Prefer Not to Say Other:		Phone #
Street Address City State Zip		
Primary Language ☐ English ☐ Other: ____________________	Race ☐ White ☐ Asian ☐ Black/African American ☐ Native American/Alaskan Native ☐ Other	Ethnicity ☐ Hispanic ☐ Non-Hispanic

Please answer the questions below for the person receiving the vaccine.	Yes	No
1. Are you feeling sick today?	☐	☐
2. Do you have any allergies (food, latex, medications)?_______________________________	☐	☐
3. Have you ever had a severe allergic reaction to something?	☐	☐
4. Have you ever had a severe allergic reaction to another vaccine or an injectable therapy?	☐	☐
5. Have you ever received a dose of COVID-19 vaccine? Which product: ________________	☐	☐
6. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
7. Have you received passive antibody therapy for COVID-19 in the past 90 days?	☐	☐
8. Have you ever had Guillain-Barré syndrome?	☐	☐
9. For women: Are you or is there a chance that you could be pregnant?	☐	☐
10. For women: Are you breastfeeding?	☐	☐

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I acknowledge that I have been offered a copy of the Pike County General Health District (PCGHD) Notice of Privacy Practices. A copy of the Emergency Use Authorization (EUA) has been provided. I have read, or have had explained, the information about the disease(s) and vaccine(s) listed. I had an opportunity to ask questions and believe that I understand the benefits of the vaccine(s). I consent to the administration of the vaccines listed to be given to the person named above and I am authorized to give this consent. I agree to the electronic transmission of immunizations and other information on this form to the Ohio Department of Health's Immunization Registry.
I authorize the PCGHD to release service related information regarding the above mentioned person to third party payers of bill for service(s) rendered to me. I request my payer pay the PCGHD directly for services rendered to me.

____ ____________________

SIGNATURE OF CLIENT or Person Authorized to Sign on the Client's Behalf **DATE**

-------------------------------------**OFFICE USE ONLY**-------------------------------------

SN	Vaccine to be Given	Lot Number	Mfr.	Fact Sheet Date	Admin Site	Route	Amount
PR OU	COVID-19		Johnson & Johnson Pfizer Moderna	12/20/20	RD / LD	IM	0.5ml 0.25ml 0.3ml 0.10ml

Raymona Minor
Autumn Osborn
Sara Ehrhart

____________________ ____________________

Date of Vaccine **Time**

Pike County General Health District

Public Health Division
116 S. Market Street
Waverly, Ohio 45690
Phone 740-947-7721 Fax 740-947-1109 mminor@pike-health.org

I ____________________________attest that I have one of the following eligibility requirements that makes me eligible to receive a third dose of the COVID-19 vaccine (Moderna or Pfizer only)

The eligibility requirements include (Please Check One):

Pfizer & Moderna (Booster)

- 65 years and older.
- Age 18 and older who live in long-term care settings.
- Age 18 and older who have underlying medical conditions.
- Age 18 and older who work or live in high-risk settings.
- For individuals who received a Pfizer-BioNTech or Moderna COVID-19 vaccine, the following groups are eligible for a booster shot at least six months after their initial series:

J&J - Janssen (Booster)

- 18 Years of age and older
- 2 months after Primary Vaccination

Moderna (Third Dose)

• 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.

Signature:_________________________________

Date:_____________________________________