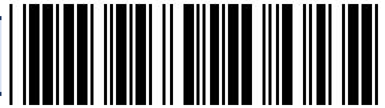
COVID-19 Vaccine Registration Form

03/09/2021



FIRST NAME	MIDDLE INITIAL	LAST NAME	SEX
			☐ Female (F) ☐ Male (M) ☐ Other (O) ☐ Unknown (U)

DATE OF BIRTH mm/dd/yyyy	AGE	17 OR UNDER?	SSN
		☐ Yes ☐ No	

PHONE NUMBER	COUNTY OF RESIDENCE	
		☐ Resident ☐ Healthcare Worker/Staff ☐ Other

STREET ADDRESS	CITY	STATE	ZIP

RACE
- ☐ Alaskan Native (5) *1002-5*
- ☐ American Indian (5) *1002-5*
- ☐ Asian (4) *2028-9*
- ☐ Black (2) *2054-5*
- ☐ Native Hawaiian (7) *2076-8*
- ☐ Pacific Islander (7) *2076-8*
- ☐ White (1) *2106-3*
- ☐ Other (6) *2131-1*
- ☐ Unknown (9)*UNK*

ETHNICITY
- ☐ Hispanic/Latino (1) *2135-2*
- ☐ Not Hispanic/Latino (2) *2186-5*
- ☐ Unknown (3) *UNK*

PATIENT QUESTIONS – ANSWER THE DAY OF VACCINATION	Dose 1	Dose 2
Do you feel sick today?	☐ No ☐ Yes	☐ No ☐ Yes
Have you had any type of vaccine in the last two weeks?	☐ No ☐ Yes	☐ No ☐ Yes
Have you ever had a severe allergic reaction to a vaccine, medication, food, or latex in the past?	☐ No ☐ Yes	☐ No ☐ Yes
Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	☐ No ☐ Yes	☐ No ☐ Yes
Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?	☐ No ☐ Yes *	☐ No ☐ Yes *
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes
Do you have any serious health conditions (often called co-morbidities)? (diabetes, obesity, lung disease)	☐ No ☐ Yes *	☐ No ☐ Yes *
Do you have a weakened immune system (ie, from HIV or cancer) or are you on immunosuppressive drugs?	☐ No ☐ Yes	☐ No ☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No ☐ Yes	☐ No ☐ Yes
Are you pregnant, planning to become pregnant in the next month, or breastfeeding?	☐ No ☐ Yes	☐ No ☐ Yes
Have you had a seizure or a brain or other nevervous system problem or Guillain Barre?	☐ No ☐ Yes	☐ No ☐ Yes

What group are you in? (select only one)

- ☐ **Assisted Living Facility Resident (TPV1)**
- ☐ **Assisted Living Facility Staff (TPV2)**
- ☐ **Skilled Nursing Facility Resident (TPV3)**
- ☐ **Skilled Nursing Facility Staff (TPV4)**
- ☐ State of Ohio DRC LTC Resident (TPV11)
- ☐ State of Ohio DRC LTC Staff (TPV12)
- ☐ Congregate Care Facility Resident (TPV13)
- ☐ Congregate Care Facility Staff (TPV14)
- ☐ Emergency Medical Services EMTs/ Paramedics (TPV21)
- ☐ Individuals over 80 years of age (TPV80)
- ☐ Individuals age 75 to 79 years of age (TPV75)
- ☐ Individuals age 70 to 74 years of age (TPV70)
- ☐ Individuals age 65 to 69 years of age (TPV65)
- ☐ Individuals with IDD and congenital disorders or early onset conditions (TPV22)
- ☐ Individuals working in K-12 schools (TPV23)
- ☐ Individuals with Congenital Disorders or Early in Life Conditions that Carried into Adulthood without IDD(TPV24)
- ☐ Diabetes Type 1 (TPV25)
- ☐ Pregnant (TPV26)
- ☐ Bone Marrow Transplant Recipient (TPV27)
- ☐ ALS (TPV28)
- ☐ Diabetes Type 2 (TPV32)
- ☐ End Stage Renal Disease (TPV33)
- ☐ Cancer (TPV34)
- ☐ Chronic Kidney Disease (TPV35)
- ☐ Chronic Obstructive Pulmonary Disease (TPV36)
- ☐ Heart Disease (TPV37)
- ☐ Obesity (TPV38)
- ☐ Individuals age 60 to 64 years of age (TPV60)
- ☐ Individuals age 50 to 59 years of age (TPV50)
- ☐ Individuals age 40 to 49 years of age (TPV40)
- ☐ Individuals age 16 to 39 years of age (TPVALL)

FIRST DOSE COVID-19 Vaccination *Facility Vaccinator MUST COMPLETE*

VACCINE NAME	LOT NUMBER	EXPIRATION DATE	MANUFACTURER
COVID-19			☐ Moderna (MOD)

ROUTE OF ADMIN	SITE OF INJECTION	VOLUME	DATE OF VACCINATION mm/dd/yyyy
☒ IM	☐ Right Deltoid (RD) ☐ Left Deltoid (LD)	☒ 0.5ml	

VACCINATOR Name (Print)	VACCINATOR Signature	FACILITY Name

ICP, Inc. Use

CCN#	Clinic Type # (Codes 29-42)	CVX Code	NDC	CPT Code	
		207	80777-273-10	Dose 1: 0011A ☐ Dose 2: 0012A ☐	☐ **State ISS Entry** ☐ **Federal CVRS Entry**

SECOND DOSE COVID-19 Vaccination *Facility Vaccinator MUST COMPLETE*

VACCINE NAME	LOT NUMBER	EXPIRATION DATE	MANUFACTURER
COVID-19			☐ Moderna (MOD)

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*CVRS Submission