Oregon Health Authority

COVID-19 Vaccine Administration Record

Write or stamp clinic address here

Patient Information

Last Name: ______________________ First Name: _________________ Middle Name: _____________

Date of Birth: _________________ Gender: Male Female

Address: ____

Mailing Address: ____

Phone Number: ____________________ Mother's Maiden Name (optional): ______________________________

Race: (Check all that apply) African American American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander White Decline to Answer

Ethnicity: Hispanic? Yes No Decline Primary Language: _______________________

Social Security Number (optional): _______ — ____ — ________ Medicaid ID Number (optional):____________

☐ I have received this clinic's HIPAA Notice of Privacy Practices

Patient Screening Questions			
	Select one:		
Do you have a fever or feel sick today?	Yes	No	
Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? Pfizer Moderna Other	Yes	No	Don't know
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	Yes	No	Don't know
Was the severe allergic reaction after receiving a COVID-19 vaccine?	Yes	No	Don't know
Was the severe allergic reaction after receiving another vaccine or another injectable medication?	Yes	No	Don't know
Have you received another vaccine in the last 14 days?	Yes	No	
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes	No	Don't know
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes	No	Don't know
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	Yes	No	
Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No	
Has the patient ever fainted after injections?	Yes	No	
Are you pregnant or breastfeeding?	Yes	No	

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Vaccine Administration Record
FOR CLINIC USE ONLY

Patient Name: ______________________________

I have received the Vaccine Information Statement(s) for the vaccines to be given and I have had all of my questions answered. I request that the vaccine be given to me or to the person named above, for whom I am responsible. I allow the release of any information needed to process insurance claims and request payments of medical benefits.

Print name: ______________________________

Signature: ______________________________

Relationship to patient: ______________________________

Date: ______________________________

For office use only

Patient risk group

1.A

1. Hospitals, urgent care, skilled nursing and memory care residents and staff, tribal health, EMS
2. LTCF, congregate care sites, hospice programs, mobile crisis care, corrections staff, secure transport
3. Outpatient settings serving high-risk, in-home care, day treatment, non-emergency medical transport
4. Outpatient health care workers, public health sites, early learning sites, death care workers

1.B

1. Essential worker
2. Person over 75 years of age

1.C

1. Person over 65 years of age
2. Person with underlying health condition

Dose #	Vaccine	Brand Name	Lot Number	Exp.	Manuf.	Dose (ML)	Site/Rte	Elig.	EUA Pub Date	EUA VIS Given
	COVID-19				Pfizer-BioNTech	0.3		S	12/2020	
					Moderna	0.5		S	12/2020	
	Other									

Vaccine Administrator Signature: ______________________ Title: ______________________ Date: ______________________