



2 <sup>nd</sup> dose return
Date: _____
Time: _____
Screening Complete: _____

**COVID-19 VACCINATION SCREENING & CONSENT**

Patient Name: \_\_\_\_\_  
Last First M.I.

Birth date: \_\_\_\_\_ Current Age: \_\_\_\_\_ Phone: \_\_\_\_\_ Gender: male female

Mailing Address: \_\_\_\_\_  
Street City State Zip Code

- Race - Physical appearance:
- White
  - Black or African American
  - Asian / Pacific Islander
  - Native American or Alaskan
  - Other / Multiracial
  - Decline

- Ethnicity - Cultural identification:
- Non-Hispanic origin
  - Hispanic origin

**Select all that apply:**

- I request Mercer County Health District to bill my insurance/Medicaid/Medicare
- I have no insurance

**Insurance Carrier's Relationship to patient:** \_\_\_\_\_ **Insurance Carrier's Employer name:** \_\_\_\_\_

**Insurance Responsible Party Name:** \_\_\_\_\_  
Last Name First Name M.I.

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Insurance Name: \_\_\_\_\_

Medicaid/Medicare/Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Authorization to pay benefits to Mercer County Health District: I authorize payment for medical services provided directly to the Mercer County Health District.

**\*\*\* No person will be denied COVID-19 vaccine because of inability to pay.**

**\*\*\* Vaccine availability will depend on supply and ODH guidelines for current tier eligibility.**

**\*\*\* The MCHD will bill for administrative costs only.**

Signature of Responsible Party: Self, Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**Turn over for Vaccine Questionnaire!!**



MERCER COUNTY  
**HEALTH DISTRICT**

**Print Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR COVID-19 VACCINE	YES	NO
1. Is the person to be vaccinated sick today?		
2. Has the person received a dose of COVID-19 vaccine in the past? Type _____ 1 <sup>st</sup> dose date: _____ 2 <sup>nd</sup> dose date: _____		
3. Does the person to be vaccinated have a history of a bleeding disorder or heparin-induced thrombocytopenia (HIT) or is on a blood thinner?		
4. Has the person to be vaccinated ever had a severe allergic reaction? Was epinephrine or EpiPen, or hospital treatment needed?		
5. Does the person have a weakened immune system caused by something such as HIV infection, cancer, or immunosuppressive drugs or therapies?		
6. Does the person have a history of myocarditis or pericarditis?		
7. Is the person to be vaccinated pregnant, considering becoming pregnant, or breastfeeding? (Now recommended for pregnant and breastfeeding women)		
8. Has the person to be vaccinated ever tested positive for COVID-19?		
9. If yes for COVID-19 disease, has the person received passive antibody therapy as treatment for COVID-19? (wait 90 days)		
10. If yes for COVID-19 disease, has the person to be vaccinated been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A)? (wait 90 days)		

I grant permission to the Mercer County Health District to give the COVID-19 vaccination to myself or the person named above for whom I am authorized to make this request (as Parent or Guardian). I have read or had explained to me the information from the Pfizer, Moderna or Janssen Fact Sheet for Recipients and Caregivers and understand the risks and benefits of this vaccine. I have received or have been offered the HIPAA Privacy Notice and understand that information will be sent to Ohio’s Immunization Information System (IMPACTSIIS). I have read or had explained to me “V-Safe After Vaccination Health Checker Information.” I understand that the person vaccinated should wait 15 minutes after receiving the vaccine. If the person leaves the vaccination site before 15 minutes have passed, I assume any risks associated with not waiting the recommended amount of time.

**Patient/Parent or Guardian**

**SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_

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**FOR HEALTH DISTRICT USE ONLY** (S:drive/2019 COVID Vaccine) 10-7-2021

FORM REVIEWED AND VACCINE ADMINISTERED BY \_\_\_\_\_

**DATE:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Moderna 0.5ml 100mcg** **LOT:** \_\_\_\_\_

**Pfizer-BioNTech 0.3ml 30mcg** **LOT:** \_\_\_\_\_

**Dose: 1 2 3**

**IM Site: LD RD LVL RVL**