Tulsa Health Department COVID-19 Worksheet

Vaccine: **Pfizer** 1st Dose ☐ 2nd Dose ☐ **Moderna** 1st Dose ☐ 2nd Dose ☐ **Janssen** ☐ **Date and Location of 1st Dose** _____

Last Name	**First Name**	**Middle Initial**	**Date of Birth**	**Age:**	**Gender:** □ Female □ Male

Street Address	**City**	**County**	**State**	**Zip Code**

Phone Number □ Cell □ Home	**Social Security #** *(Optional)*	**Ethnicity: Hispanic Origin** ☐ Yes ☐ No	**Race:** □ American Indian/Alaskan Native □ Asian □ Black/African American □ White □ Native Hawaiian/Other Pacific Islander

Language: ☐ English ☐ Spanish ☐Other **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Do you give permission for us to contact you: ☐ Yes ☐ No **Email Address:**

Medical Insurance Information

Does patient have medical health insurance ☐ Yes ☐ No If yes, please complete questions below

☐ **Medicaid/Soonercare**	Medicaid Number:	First and Last name as it appears on card	Mothers Maiden Name:	
☐ **Private Insurance**	Indicate Primary insurance:	Policy Holder:	Group No.:	Policy ID No.:
	Indicate Secondary insurance:	Policy Holder:	Group No.:	Policy ID No.:
☐ **Medicare**	Do you have Medicare Part B: ☐ Yes ☐ No	Is Medicare Primary? ☐ Yes ☐ No	Medicare Number:	

Consent: I, the undersigned, give my consent for the services that I am requesting from the Tulsa Health Department (THD) and its entities/contractors. I acknowledge that I received the vaccine manufacturer Fact Sheet for Recipients and Caregivers prior to receiving the vaccine and have had the opportunity to ask questions. I understand the benefits and risks of the vaccine and request it be administered to me or the person for whom I am authorized to make consent. I have reviewed the Notice of Health Information Practices (HIPAA) and understand the information may be provided to public health officials, health care professionals and insurance processing entities.

Patient Signature_____ **Date:**_____

For Minors only: Parent or Guardian Signature: _____ **Relationship to Patient:** _____

Medical Screening:

1. Do you have a fever (>100F), infection or current illness today? Yes No
2. Do you have an allergy to a previous dose of Covid vaccine or a component of the Covid vaccine? Yes No
3. Have you had a severe allergic reaction (anaphylactic) to something else ((food, pet, insect bite, etc.) Yes No
4. Have you received passive antibody therapy as treatment for COVID-19? Yes No
5. Have you ever had a significant allergic reaction to another vaccine or other injection? Yes No
6. Are you pregnant, plan to be pregnant or currently breastfeeding? Yes No
7. Do you have a bleeding disorder or are you taking a blood thinner? Yes No
8. Do you have a severely immunocompromising condition? Yes No
9. Have you received another vaccine in the last 14 days? Yes No
10. Do you have dermal fillers? Yes No

Date Administered	Vaccine Type	Manufacturer	Lot Number/ Exp Date	Site
	Covid Vaccine			

OSIIS Data Entry Clerk Int. & Date completed	iPad Portal Complete

Nurse / Vaccine Administrator: **Print Name**_____ **Signature**_____