

Clinic: _____

Today's Date: _____

COVID-19 Vaccination Form Please complete each field below with the information that applies to the client receiving services today.

CLIENT INFORMATION								
Name (Last, First, MI)				Suffix (eg., Jr, III)		Date of Birth		Age†
Street Address				City		State	Zip	County
Phone Number ()		<input type="checkbox"/> Cell <input type="checkbox"/> Home	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Race <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	
If the client is under 18 years of age, please complete guardian information. Guardian relationship to client: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other Guardian Name (Last, First) _____								
CONSENT FOR SERVICE								
<p>I, the undersigned, give my consent for the services that I am requesting from the Oklahoma State Department of Health (OSDH) and its entities/contractors. I understand that:</p> <ul style="list-style-type: none"> -- the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions. -- the information regarding myself and the services I receive will be entered into OSDH management information systems and may be used for program evaluation, management, and billing purposes. -- I may refuse service at any time. <p>I acknowledge that I have received a copy of the Oklahoma State Department of Health Privacy Statement as required by the Health Information Portability and Accountability Act (HIPAA). I can also find a copy on the agency website. I also acknowledge that I received the manufacturer-specific Fact Sheet for Recipients and Caregivers prior to receiving the vaccine.</p> <p>Client/Guardian Signature: _____ Date: _____</p>								

†Client must be aged 16 years or older to receive the vaccine.

****FOR OSDH USE ONLY****

Client Name (Last, First, MI) _____ Client DOB (MM/DD/YYYY) _____

OFFICE USE ONLY – DO NOT WRITE BELOW

Client completed the manufacturer's screening questions: Y N

Vaccine Manufacturer:

Lot #:

Exp. Date:

Site:

LT DELTOID IM

RT DELTOID IM

LT VAST LAT IM

RT VAST LAT IM

EUA*/VIS given? Y N

Reaction? Y N

Dose Number:

1st 2nd

Vaccination Complete? Complete Refused Not administered Partially administered No recorded completion status

Provider Signature:

*EAU = Emergency Use Agreement

Progress Note: _____
