Vaccination Pod at Case Western Reserve University

CASE WESTERN RESERVE UNIVERSITY EST. 1826

Target Population Code

COVID-19 Vaccine Registration Form

FIRST NAME	MIDDLE INITIAL	LAST NAME	CVX CODE	CPT CODE

DATE OF BIRTH	AGE	WEIGHT (LBS)	17 OR UNDER?	MISSED APPOINTMENT	REFUSAL
/ /			☐ Yes ☐ No	☐ Yes ■ No	☐ Yes ■ No

PHONE NUMBER OK To Text? Yes No

EMAIL Ok To Email? Yes No

STREET ADDRESS

RACE
- ☐ Alaskan Native (5)
- ☐ American Indian (5)
- ☐ Asian (4)
- ☐ Black (2)
- ☐ Native Hawaiian (7)
- ☐ Pacific Islander (7)
- ☐ White (1)
- ☐ Other (6)
- ☐ Unknown (9)

ETHNICITY
- ☐ Hispanic/Latino (1)
- ☐ Not Hispanic/ Latino (2)
- ☐ Unknown (3)

SEX
- ☐ Female (F)
- ☐ Male (M)
- ☐ Other (O)
- ☐ Unknown (U)

CITY	STATE	ZIP	COUNTY OF RESIDENCE

PATIENT QUESTIONS — ANSWER THE DAY OF VACCINATION

Question	No	Yes
Have you had any type of vaccine in the last two weeks?	☐ No	☐ Yes
Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to a vaccine or any injection, or a history of anaphylaxis due to any cause?	☐ No	☐ Yes
Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?	☐ No	☐ Yes
Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	☐ No	☐ Yes
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?	☐ No	☐ Yes
Do you have any serious health conditions (often called co-morbidities)?	☐ No	☐ Yes
Do you have a weakened immune system (i.e., from HIV or cancer) or are you on immunosuppressive drugs?	☐ No	☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No	☐ Yes
Are you pregnant or breastfeeding?	☐ No	☐ Yes
Do you feel sick today?	☐ No	☐ Yes

Is this your first or second dose in the last month? ☐ First Dose ☐ Second Dose	First dose manufacturer	First dose date

I have been provided with and reviewed the Vaccine Fact Sheet for the COVID-19 vaccine that I am receiving. I understand the FDA has authorized emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any adverse events that may result. I understand that Case Western Reserve University is a teaching institution and healthcare personnel in training may be present and participate in providing services. I hereby release Case Western Reserve University, its employees, trustees, officers, faculty, students, representatives, agents, successors and assigns, from any liability which could result from this vaccination. I acknowledge that the federal Public Readiness and Emergency Preparedness (PREP) Act Declaration extends liability protections to entities and individuals who manufacture, distribute, or administer covered medical countermeasures against a public health threat or emergency. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. By signing below, I, as or on behalf of the Patient, consent to receive and authorize Case Western Reserve University to provide the services. I understand that Case Western Reserve University may disclose my health information as set forth in the CWRU Notice of Privacy Practices, or as necessary for payment or to report to county, state, and/or federal agency. I authorize Case Western Reserve University to contact me for any purpose by any means I have provided. I understand that an administration fee may be billed to third party payers. I authorize Case Western Reserve University to bill any and all third party payers for this service. I agree that if I leave the vaccination site before 15 minutes have passed after my vaccination, I assume any risks associated with not waiting the recommended amount of time. I am aware that staff may be taking pictures for social media and clinic improvement purposes. If I do not want my picture to be taken, I will let Case Western Reserve University know.

PATIENT CONSENT/SIGNATURE (OR PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE IF THE PATIENT IS AGE 17 OR UNDER)	DATE OF CONSENT
	/ /

OFFICE USE ONLY

VACCINE NAME	LOT NUMBER	EXPIRATION DATE	DOSE SIZE
COVID-19			■ Full (1.0) ☐ Half (0.5)

MANUFACTURER
- ☐ Moderna (MOD)
- ☐ Pfizer (PFR)
- ☐ AstraZeneca (ASZ)
- ☐ GlaxoSmithKline
- ☐ Johnson & Johnson (JNJ)
- ☐ Merck
- ☐ Novavax
- ☐ Sanofi

ROUTE OF ADMIN	SITE OF INJECTION	DOSE IN SERIES	SERIES COMPLETE?
■ IM ☐ TD ☐ IV ☐ NS ☐ SC ☐ ID ☐ O ☐ Other	☐ RA ☐ RD ☐ RT ☐ Other ☐ LA ☐ LD ☐ LT ____________	☐ First ☐ Second	☐ Yes ☐ No

VACCINE GROUP	VACCINATOR	DATE/TIME OF VACCINATION	OCCUPATION

CLINIC LOCATION	CLINIC TYPE	CLINIC ADDRESS	STATE VACCINE SYSTEM DATA ENTRY
			☐ By clinic/agency GIVING vaccine (N) ☐ By clinic/agency NOT giving vaccine (Y)

SYMPTOMS AND OUTCOME OF THE ADVERSE EVENT(S) (IF APPLICABLE)	MEDICAL TESTS AND LABORATORY RESULTS (IF APPLICABLE)	PHYSICIAN'S CONTACT INFORMATION (IF APPLICABLE)

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INFORMATION ABOUT POPULATION AND/OR OCCUPATION

Instructions: Please **check only one box** in the section below. Please select the **primary reason** you are receiving the COVID-19 vaccine.

PHASE 1A

- ☐ Assisted Living Facility – Resident
- ☐ Assisted Living Facility – Staff
- ☐ Skilled Nursing Facility (RCF) – Resident
- ☐ Skilled Nursing Facility (RCF) – Staff
- ☐ State of Ohio Dept. of Dev. Disabilities (DODD) – Resident
- ☐ State of Ohio Dept. of Dev. Disabilities (DODD) – Staff
- ☐ State of Ohio Veterans Home – Resident
- ☐ State of Ohio Veterans Home – Staff
- ☐ State of Ohio Mental Health and Addiction Services (MHAS) – Resident
- ☐ State of Ohio Mental Health and Addiction Services (MHAS) – Staff
- ☐ State of Ohio Dept. of Rehabilitation & Correction – LTC residents
- ☐ State of Ohio Dept. of Rehabilitation & Correction – LTC staff
- ☐ Congregate Care Facility – Resident
- ☐ Congregate Care Facility – Staff
- ☐ Hospital worker – Clinical Staff
- ☐ Hospital worker – Administrative Staff
- ☐ Hospital worker – Ancillary Staff
- ☐ Non-Hospital healthcare worker – Administrative Staff
- ☐ Non-Hospital healthcare worker – Ancillary Staff
- ☐ Non-Hospital healthcare worker – Clinical Staff
- ☐ Emergency Medical Services (EMTs/Paramedics)

PHASE 1B

- ☐ Individuals over 80 years of age
- ☐ Individuals age 75 to 79 years of age
- ☐ Individuals age 70 to 74 years of age
- ☐ Individuals age 65 to 69 years of age
- ☐ Individuals with Congenital Disorders or Early Onset Conditions with IDD
- ☐ Individuals working in K-12 schools
- ☐ Individuals with Congenital Disorders or Early in Life Conditions that Carried into Adulthood without IDD

PHASE 1C

- ☐ Diabetes Type1
- ☐ Pregnant
- ☐ Bone Marrow Transplant Recipients
- ☐ ALS
- ☐ Childcare Services Worker
- ☐ Funeral Services Worker
- ☐ Law Enforcement, Corrections, Firefighter

PHASE 1D

- ☐ Diabetes Type 2
- ☐ End Stage Renal Disease

PHASE 1E

- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Heart Disease
- ☐ Obesity

PHASE 2A

- ☐ Individuals age 60 to 64 years of age

PHASE 2B

- ☐ Individuals age 50 to 59 years of age

PHASE 2C

- ☐ Individuals age 40 to 49 years of age

PHASE 2D

- ☐ Individuals age 16 to 39 years of age