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 ☐ Cell ☐ Home ( )	**Sex** ☐ Female ☐ Male ☐ Other ☐ Unknown	**Race** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other		**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	

If the client is under 18 years of age, please complete guardian information.
Guardian relationship to client: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Other **Guardian Name (Last, First)** _____, _____, ___

CONSENT FOR SERVICE

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:

-- 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.

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.

Client/Guardian Signature: _____ Date: _____

†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:_____

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