Tulsa Health Department COVID-19 Worksheet

COVID Vaccine

DOSE 1 ☐ DOSE 2 ☐

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 #	Ethnicity: Hispanic Origin ☐ Yes ☐ No	Race: ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ White

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 No.:
	Indicate Secondary insurance:	Policy Holder:	Group No.:	Policy 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 / Parent or Guardian Signature: ________________________ **Relationship to Patient:**________________ **Date:**____________

Medical Screening:

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

Date	Vaccine Type	Manufacturer	Lot Number	Exp. Date	Site
	COVID Vaccine				

Data Entry
OSIIS Complete Clerk Initial

Nurse/Vaccine Administrator:

Print Name________________________ **Signature**________________________