Wyandot County Public Health
Covid-19 Administration Record
Patient Financial Responsibility Form

PLEASE PRINT CLEARLY

Last Name **First Name** **M.I.**

Address **City** **State** **Zip**

Phone Number **Parent/Guardian Name (only if client is under age 18)**

Birth Date **Age** **Sex** Male Female

Please answer the questions below:

Are you pregnant or breastfeeding?	Yes	No
Are you allergic to polyethelene glycol or any other components of the vaccine?	Yes	No
Have you ever had a reaction from a vaccine in the past?	Yes	No
Do you currently have Covid-19	Yes	No

I have read or have had explained to me the information regarding Covid-19 disease and the Covid-19 vaccine. I had the opportunity to ask questions that were answered to my satisfaction and received a Vaccine Information Sheet. I believe I understand the benefits and risk of the Covid-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I understand information regarding my vaccine may be transferred to the Ohio Department of Health Immunization Program. I acknowledge that I have been offered or received a copy of the notice of privacy practices for Wyandot County Public Health (WCPH). I give my consent to use and disclose my protected health information for the purposes of treatment and payment of my health care. My signature is also agreement to provide payment of all charges at the time of service.

Patient or Guardian Signature_____

Date Signed_____

For Office Use Only

	INSURANCE	**SELF-PAY**
	Medicare (Traditional Part B) ID#_____	☐ Cash
	Medicare HMO (ex. Anthem Medicare Advantage, Aetna Medicare Advantage)	☐ Check #_____
	Name of plan:_____ ID#_____	☐ Credit Card
	Medicaid (ex.Traditional Medicaid, CareSource, Molina, Buckeye, Paramount)	Type_____
	Name of plan:_____ ID#_____	CC#_____
	Private Insurance Company Name_____	Exp. Date_____
	Member ID:_____Group:_____Plan:_____	Amount:_____
	Policy Holder Name & Date of Birth:_____ ___/___/___	Receipt #_____
	Relationship to Policy Holder:_____	Received by:_____

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Vaccine Administered Information

Date	Vaccine Name	Vaccine Lot #	Exp. Date	Mfg.	IM Site	Dose	Staff initials
						0.5 ml	
Initial Dose Booster Dose					VIS:		

Ohio | Department of Health

Population/Occupation Data Checklist for COVID-19 Vaccine Recipients

Purpose: This checklist will be used to collect population and occupation information for COVID-19 vaccine recipients.

SECTION 1: INFORMATION ABOUT VACCINE RECIPIENT (PLEASE PRINT)

VACCINE RECIPIENT'S NAME	(First)	(M.I.)	(Last)
DATE OF BIRTH	(Month)	(Day)	(Year)

SECTION 2: 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.

TARGET POPULATION/OCCUPATION

- ☐ 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)