

# 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# _____	<input type="checkbox"/> Cash
Medicare HMO (ex. Anthem Medicare Advantage, Aetna Medicare Advantage) Name of plan: _____ ID# _____	<input type="checkbox"/> Check # _____
Medicaid (ex. Traditional Medicaid, CareSource, Molina, Buckeye, Paramount) Name of plan: _____ ID# _____	<input type="checkbox"/> Credit Card
Private Insurance Company Name _____ Member ID: _____ Group: _____ Plan: _____	Type _____ CC# _____
Policy Holder Name & Date of Birth: _____ / ____ / ____ Relationship to Policy Holder: _____	Exp. Date _____ Amount: _____ Receipt # _____ Received by: _____

For Office Use Only							
Vaccine Administered Information							
Date	Vaccine Name	Vaccine Lot #	Exp. Date	Mfg.	IM Site	Dose	Staff initials
	Moderna			Moderna		0.5 ml	
Initial Dose	Booster Dose					VIS:	

## 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)

<b>VACCINE RECIPIENT'S NAME</b>			
	(First)	(M.I.)	(Last)
<b>DATE OF BIRTH</b>			
	(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

##### 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 IDD and Congenital Disorders or Early Onset Conditions
- Individuals working in K-12 schools
- Individuals without IDD and Congenital Disorders or Early Onset Conditions