Wyandot County Public Health
127- A South Sandusky Avenue
Upper Sandusky, OH 43351
Phone 419-294-3852 | Fax 419-294-6424
www.wyandothealth.com

COVID-19 Immunization Screening Consent Form

Ages (18 years and older)

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 (circle):** Male Female

Race/Ethnicity:

By signing below, I acknowledge that 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 understand the Covid-19 Moderna vaccine is available under EUA. The vaccine has not completed the same type of review as an FDA-approved product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known or potential risks. I understand the 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 also displays my understanding that there will be no cost to me for the Covid-19 vaccination at this time.

Patient Signature (or Guardian)_____

Date Signed_____

For Office Use Only

INSURANCE		**SELF-PAY**		
	Medicare (Traditional Part B) ID#_____			
	Medicare HMO (ex. Anthem Medicare Advantage, Aetna Medicare Advantage) Name of plan:_____ ID#_____			
	Medicaid (ex.Traditional Medicaid, CareSource, Molina, Buckeye, Paramount) Name of plan:_____ ID#_____	**Insurance copied**	**Insurance on file**	**EUA Fact Sheet Date**
	Private Insurance Company Name_____	Yes / No	Yes / No	8/31/2022
	Member ID:_____Group:_____Plan:_____		**Staff initials**	
	Policy Holder Name & Date of Birth:_____ ___/___/___ Relationship to Policy Holder:_____			

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To be completed by nurse administering vaccine:

Date	**Vaccine Name**	**Vaccine Lot #**	**Expiration Date**	**Manufacturer**	**IM Site**	**Dose (Circle one)**	**Staff initials**
	Moderna (18 and up)			Moderna	LD / RD	Bivalent Booster - **0.5 mL (50 µg)**	

☐ First Dose ☐ Second Dose ☐ Third Dose ☐ Fourth Dose ☐ Other Dose

____ I have verified that this client is immunocompromised / is not immunocompromised. ***(Circle one)***
____ I have verified that it has been at least **2 months** since the previous dose (if receiving booster)
____ I have verified that this client has completed a **primary series** at least 2 months ago (if receiving booster)
____ This individual is receiving the *monovalent* / *bivalent* Moderna vaccine ***(Circle one)***
____ If *Other Dose* is marked above, please specify here:

Monovalent Primary dose - **0.5 mL (100 µg)**

Clinic Site:

Updated 9.28.22