Oregon Health Authority

COVID-19 Vaccine Administration Record

Baker County Health Department
2200 4th St
Baker City, OR 97814
Phone: 541-523-8211
Write or stamp clinic address here
Fax: 541-523-8242

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Gender: Male ☐ Female ☐

Address: _____

Mailing Address: _____

Phone Number: _____ Mother's Maiden Name (optional): _____

Race: (Check all that apply) African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline to Answer ☐

Ethnicity: Hispanic? Yes ☐ No ☐ Decline ☐ Primary Language: _____

Social Security Number (optional): _____ – _____ – _____ Medicaid ID Number (optional): _____

☐ I have received this clinic's HIPAA Notice of Privacy Practices

Patient Screening Questions

	Select one:		
Do you have a fever or feel sick today?	Yes ☐	No ☐	
Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? Pfizer Moderna Other	Yes ☐	No ☐	Don't know ☐
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	Yes ☐	No ☐	Don't know ☐
Was the severe allergic reaction after receiving a COVID-19 vaccine?	Yes ☐	No ☐	Don't know ☐
Was the severe allergic reaction after receiving another vaccine or another injectable medication?	Yes ☐	No ☐	Don't know ☐
Have you received another vaccine in the last 14 days?	Yes ☐	No ☐	
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes ☐	No ☐	Don't know ☐
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes ☐	No ☐	Don't know ☐
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	Yes ☐	No ☐	
Do you have a bleeding disorder or are you taking a blood thinner?	Yes ☐	No ☐	
Has the patient ever fainted after injections?	Yes ☐	No ☐	
Are you pregnant or breastfeeding?	Yes ☐	No ☐	

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Vaccine Administration Record
FOR CLINIC USE ONLY

Patient Name: _____

I have received the Vaccine Information Statement(s) for the vaccines to be given and I have had all of my questions answered. I request that the vaccine be given to me or to the person named above, for whom I am responsible. I allow the release of any information needed to process insurance claims and request payments of medical benefits.

Print name: _____

Signature: _____

Relationship to patient: _____

Date: _____

For office use only

Patient risk group

1.A
- ○ 1. Hospitals, urgent care, skilled nursing and memory care residents and staff, tribal health, EMS
- ○ 2. LTCF, congregate care sites, hospice programs, mobile crisis care, corrections staff, secure transport
- ○ 3. Outpatient settings serving high-risk, in-home care, day treatment, non-emergency medical transport
- ○ 4. Outpatient health care workers, public health sites, early learning sites, death care workers

1.B
- ○ 1. Essential worker
- ○ 2. Person over 75 years of age

1.C
- ○ 1. Person over 65 years of age
- ○ 2. Person with underlying health condition

Dose #	Vaccine	Brand Name	Lot Number	Exp.	Manuf.	Dose (ML)	Site/Rte	Elig.	EUA Pub Date	EUA VIS Given
	COVID-19				Pfizer-BioNTech	0.3		S	12/2020	
					Moderna	0.5		S	12/2020	
	Other									

Vaccine Administrator Signature: _____ Title: _____ Date: _____