Oregon Health Authority

COVID-19 Vaccine Administration Record

Baker County Health Department
2200 4th Street Baker City, OR 97814
Phone: 541-523-8211
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 (circle all that apply): African American American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander White Decline to Answer

Ethnicity (circle selection): Hispanic? Yes No Decline Primary Language: _________________

Social Security Number (optional):___________________ Medicaid ID Number (optional): _________________

☐ I understand that the HIPAA Notice of Privacy Practices are available upon request.

Patient Screening Questions	Circle 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: 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	

I have received the Emergency Use Authorization for the vaccine 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

Print Patient Name ______________________________

Dose #	Vaccine	Brand Name	Lot Number	Exp.	Manuf.	Dose (ML)	Site/Rte	Elib.	EUA Pub Date	EUA VIS Given
	COVID-19					0.5		S	Dec-20	
	Other									

Vaccine Administrator Signature:_______________________________ Title:___________________ Date:_____________