

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 _____

Revised 10-13-2022

Dose #	Vaccine	Brand Name	Lot Number	Exp.	Dose (ML)	Site/Rte	Elib.	EUA Pub Date	EUA VIS Given
	COVID-19	Peds Pfizer 6 mo - 4 yr			0.2		S	6-17-2022	
	COVID-19	Peds Pfizer 5-12 yr			0.2		S	6-17-2022	
	COVID-19	Peds Pfizer Bivalent Booster 5-12yr			0.2		S	10-12-2022	
	COVID-19	Pfizer 12 +			0.3		S	6-17-2022	
	COVID-19	Pfizer Bivalent Booster (12 +)			0.3			8-31-2022	
	COVID-19	Moderna Peds 6 mo – 5 yr			0.25		S	6-17-2022	
	COVID-19	Moderna Peds 6-11 yr			0.5		S	6-17-2022	
	COVID-19	Moderna Peds Bivalent booster 6-11 yr/ 12-17 yr			0.25 (6-11) 0.5 (12-17)		S	10-12-2022	
	COVID-19	Moderna 18 +			0.5		S	6-17-2022	
	COVID-19	Moderna Bivalent Booster (18+)			0.5		S	8-31-2022	
	COVID-19	Novavax 12 +			0.5		S	8-19-2022	

Vaccine Administrator Signature: _____ Title: _____ Date: _____