



Trumbull County Combined Health District
 176 Chestnut Ave NE
 Warren, OH 44483
 330-675-2489
 Frank J. Migliozi, MPH, REHS/RS, Health Commissioner



- 1st Dose
- 2nd Dose
- 3rd Dose
- Pfizer
- Moderna
- J&J

COVID- 19 Vaccine Administration Record

This record will be kept on file at the Trumbull County Combined Health District. It acknowledges that the person has read and/or understands information about the Covid-19 vaccination.

Please Print Clearly:

First Name: _____ Last Name: _____
 Date of Birth: _____ AGE: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Gender: MALE or FEMALE Phone: _____

Race: White African American Asian Hispanic American Indian Other

- | | | | |
|----|---|----|-----|
| 1. | Are you Sick Today? (Fever, Congestion, etc.) | NO | YES |
| 2. | Have you been diagnosed with Covid-19 in the past 30 days | NO | YES |
| 3. | Are you Pregnant? | NO | YES |
| 4. | Are you Breastfeeding? | NO | YES |
| 5. | Have you ever had an allergic reaction to an immunization? | NO | YES |
| 6. | Do you have a history of Anaphylaxis? (Severe Allergic reactions) | NO | YES |

IF YES PLEASE EXPLAIN:

For Those Requesting a Booster Dose:

I attest that I am eligible for a booster dose of vaccine based on the criteria below. I received a second dose of Pfizer or Moderna COVID-19 vaccine at least 6 months ago; or a dose of J&J COVID-19 vaccine at least 2 months ago; **AND** I am age 65 years or older, OR I live in a long-term care setting, OR I am age 18-64 and am at increased risk for COVID-19 exposure and transmission because of my work or institutional setting, OR I am age 18-64 and I have an underlying medical conditions:

Signature

For Those Requesting a Third Dose:

I attest that I am immunocompromised and am requesting a third dose. _____

Signature

I have received a copy and have read or had read to me the information contained in the appropriate Vaccine Information Statement(s) or EUA in my primary language about the disease(s) and vaccine(s) checked above. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) indicated on this record be given to me or the person named above for whom I am authorized to make this request. I also grant permission for this record to be released to medical providers, health departments, schools, daycare centers, community and state immunization registry databases. I have seen or received a copy of the Notice of Privacy Practices for The Trumbull County Combined Health District and have had a chance to ask any questions concerning this.

Patient/Parent/Guardian Signature _____ Date _____

Clinic Use Only:	
Clinic Name: Trumbull County Combined Health District Clinic	Vaccine Manuf.:
Address: 176 Chestnut Ave. NE, Warren, Ohio 44483	Exp. date:
Date administered:	Lot No#:
Injection Site: LA RA Administered by:	