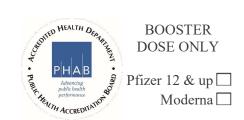


BOOSTER DOSE ONLY



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.

	rint Clearly								
Date of	Date of Birth: _		Last Name: AGE:						
Addre	ess:								
City: _				State:	2	Zip:			
Gender	: MALE or	FEMALE	,	Phon	e:				
Race:	White	Africa	n American	Asian His	panic	American	Indian	Other	
1.	Are you	Sick Toda	ay? (Fever, C	ongestion, et	c.)		NO	YES	
2.	. Have you been diagnosed with Covid-19 in the past 30 days						NO	YES	
3.	Are you	re you Pregnant?						YES	
4.	Are you	you Breastfeeding?						YES	
5.	Have yo	ve you ever had an allergic reaction to an immunization?						YES	
6.	Do you	have a his	tory of Anapl	nylaxis? (Sev	ere Allergi	c reactions)	NO	YES	
Vaccine Invaccine(s) of satisfaction indicated of this request department I have seen Combined. Patient/Pare			read or had read or EUA in the had a chance to me or the ion for this reacters, comming the Notice of the Notice of the had a chance to me or the second of the Notice of	my primary le to ask ques s and risks of person name cord to be reunity and state of Privacy Prance to ask an	anguage al tions which the vaccir d above fo leased to m e immunizactices for y questions		ease(s) an ered to me that the authorized and authorized at a databased at the authorized at a databased at a d	vaccine(s) zed to make alth ses.	
Clinic Name:	Clinic Use Only: Clinic Name: Trumbull County Combined Health District Clinic Vaccine Manuf.:								
Address: 176	Address: 176 Chestnut Ave. NE, Warren, Ohio 4-					Exp. date	e:		
Pate administered:					Lot No#:				
Injection Site	e: LA	RA	Administer	red by:					
Date/Type of	Primary S	Series:							