COVID-19 Vaccination Registration Form

The following questions will help determine if there is any reason, we should not give you or your child the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Information

First Name: _____ **Last Name:** _____

Date of Birth: _____/_____/_____ **Age:** _____

Address: _____

City: _____ **Zip code:** _____

Phone Number: _____ **Email:** _____

Race and Ethnicity Information (check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ More than one race ☐ Other

Please answer the following:

Are you a critical/essential worker? ☐ Yes ☐ No

Have you tested positive for COVID-19? ☐ Yes ☐ No

Are you a care facility worker/resident? ☐ Yes ☐ No

Are you experiencing homelessness? ☐ Yes ☐ No

Do you have any health conditions? ☐ Yes ☐ No

Medical Screening Questions	Yes	No
Are you feeling sick today?		
Have you ever received a dose of COVID-19 Vaccine?		
Have you ever had an allergic reaction to: 1. A component of the COVID-19 Vaccine, including Polyethylene Glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures, 2. Polysorbate, 3. A previous dose of COVID-19 vaccine? (This would include severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen© or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen© or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.		
Have you received any vaccine in the last 14 days?		
Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?		
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
Do you have a bleeding disorder or are you taking a blood thinner?		
Are you pregnant or breastfeeding?		

FOR STAFF USE ONLY

Name: _____ Signature: _____

Date: _____/_____/_____ Time:_____

Product:_____ COVID-19 Dose: _____ mL Asset Name: _____

Injection Site: RD LD RL LL Route: IM SQ