Robert M. Damminger
Director

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Department of Health

COVID-19 Vaccination Paper Registration Form

Instructions: Please complete the patient information section below and return it to the nurse prior to receiving your vaccination. Please print all information clearly and accurately.

PATIENT INFORMATION

Name (Last, First):

_____

Date of Birth (DOB): _____

Primary Residential Address:

_____

Street *City* *State* *ZIP*

Profession/Job Title:

_____

Phone Number (Where we can best reach you):

_____

Email Address:

_____

Birth Country:

_____

Please indicate if you are a twin, triplet, or quadruplet by checking the box below.

Twin: ☐ Triplet: ☐ Quadruplet: ☐

Race: White: ☐ Black/African American: ☐ Asian: ☐ American Indian or Alaska Native: ☐

Native Hawaiian or other Pacific islander: ☐ Other: ☐

Ethnicity: Hispanic: ☐ Non-Hispanic: ☐ Prefer not to specify: ☐

Sex: Male: ☐ Female: ☐

	YES	NO	DON'T KNOW
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? If yes, which product? _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something?			
4. Have you ever had an allergic reaction to Polyethylene Glycol (PEG), Polysorbate, or a previous dose of covid 19 vaccine?			
5. Were you ever diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID 19 infection?			
6. Do you have a bleeding disorder or are you taking a blood thinner?			
7. Have you received passive antibody therapy as treatment for COVID-19?			
8. Have you received dermal fillers?			
9. Do you have a history of heparin-induced thrombocytopenia (HIT)?			
10. Do you have a weakened immune system or take immunosuppressive drugs (i.e HIV, cancer)?			

I have received the COVID-19 Emergency Use Agreement. I believe that I understand the benefits and the risks of vaccine and request that the vaccine be given to me or the person named above for whom I am authorized to make this request. Print Parent Name: _____ Phone: _____

Parent Signature _____Date_____

OFFICIAL USE ONLY

Vaccine Manufacturer: Pfizer ☐ Moderna ☐ Janssen ☐

Dose: First ☐ Second ☐ ***If first dose, date/time second dose scheduled:*** _____

Vaccination Site: Right Deltoid ☐ Left Deltoid ☐ Other _____ ☐

Vaccine Lot Number: _____ **Vaccine Expiration Date:** _____

Vaccine Administered By (Please Print) _____

Signature:_____

Other Notes:_____