



# 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:** \_\_\_\_\_ **Gender:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Mother or Guardian's First name:** \_\_\_\_\_  
**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

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Medical Screening Questions	Yes	No
Are you feeling sick today?		
Have you ever received a dose of COVID-19 Vaccine? If so, which vaccine? _____		
Have you ever had an allergic reaction to: <ol style="list-style-type: none"> <li>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,</li> <li>2. Polysorbate,</li> <li>3. A previous dose of COVID-19 vaccine? (This would include severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen<sup>®</sup> 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.)</li> </ol>		
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 <sup>®</sup> 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 in the last 90 days?		
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? I understand that the best source of pregnancy risk information is my healthcare provider.		

<b>FOR STAFF USE ONLY</b>		
Name _____	Signature: _____	
Date: ____/____/____	Time: _____	
Product: _____ COVID-19	Dose: _____ mL	Lot #: _____
Injection Site:    RD    LD    RL    LL	Route:    IM    SQ	