ID_____

COVID-19 Vaccine Registration Form

06/25/2021

FIRST NAME	MIDDLE INITIAL	LAST NAME	CVX CODE	CPT CODE

DATE OF BIRTH	AGE	17 OR UNDER?	MISSED APPT	REFUSAL
/ /		☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No

PHONE NUMBER	OK TO TEXT? Yes No	EMAIL	OK TO EMAIL? Yes No

STREET ADDRESS

RACE
- ☐ Alaskan Native (5)
- ☐ American Indian (5)
- ☐ Asian (4)
- ☐ Black (2)
- ☐ Native Hawaiian (7)
- ☐ Pacific Islander (7)
- ☐ White (1)
- ☐ Other (6)
- ☐ Unknown (9)

ETHNICITY
- ☐ Hispanic/Latino (1)
- ☐ Not Hispanic/Latino (2)
- ☐ Unknown (3)

SEX
- ☐ Female (F)
- ☐ Male (M)
- ☐ Other (O)
- ☐ Unknown (U)

CITY	STATE	ZIP	COUNTY OF RESIDENCE

NAME OF INSURANCE:	MEMBER ID:

INSURANCE INFORMATION ☐ **NO INSURANCE**

RESPONSIBLE PARTY (GUARANTOR) ☐ **SAME AS PATIENT**

FIRST NAME	LAST NAME	MI	DATE OF BIRTH
			/ /

PATIENT QUESTIONS – ANSWER THE DAY OF VACCINATION

Have you had any type of vaccine in the last two weeks?	☐ No	☐ Yes
Have you ever had a severe allergic reaction to a vaccine or any injection in the past?	☐ No	☐ Yes
Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?	☐ No	☐ Yes
Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	☐ No	☐ Yes
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?	☐ No	☐ Yes
Do you have any serious health conditions (often called co-morbidities)?	☐ No	☐ Yes
Do you have a weakened immune system (ie, from HIV or cancer) or are you on immunosuppressive drugs?	☐ No	☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No	☐ Yes
Are you pregnant or breastfeeding?	☐ No	☐ Yes
Do you feel sick today?	☐ No	☐ Yes
Is this your first or second dose in the last month?	☐ First dose	☐ Second dose

First dose manufacturer _____
First dose date _____

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to learn about the benefits and risks (VIS) of the COVID-19 vaccine. Please visit our website (posted at the clinic) to read our Privacy Policy (PP). By signing below, you agree that 1) you reviewed both the VIS and PP, 2) you understand the benefits and risks of the vaccine and you are asking that the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby consent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record and all information on this form to your state's Immunization Program and the CDC, and 5) we can release this record to your doctor, school, or employer if requested. If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient and the patient on this form may receive vaccine with or without you, as the parent or guardian, present at the time of vaccination. After receiving your vaccine we recommend you wait at least 15 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time. Please be aware that staff may be taking pictures for social media and clinic improvement purposes. If you do not want your picture to be taken please let us know at the clinic .

PATIENT CONSENT/SIGNATURE (or parent/guardian if patient is age 17 or under)	DATE OF CONSENT
	/ /

OFFICE USE ONLY

VACCINE NAME	LOT NUMBER	EXPIRATION DATE	DOSE SIZE
COVID-19			☒ Full (1.0) ☐ Half (0.5)

MANUFACTURER
- ☐ Moderna (MOD)
- ☐ Johnson & Johnson (JNJ)
- ☐ Pfizer (PFR)
- ☐ Merck
- ☐ AstraZeneca (ASZ)
- ☐ Novavax
- ☐ GlaxoSmithKline
- ☐ Sanofi

ROUTE OF ADMIN	SITE OF INJECTION	DOSE IN SERIES	SERIES COMPLETE?
☒ IM ☐ TD ☐ IV ☐ NS ☐ SC ☐ ID ☐ O ☐ Oth	☐ RA ☐ RD ☐ RT ☐ Other ☐ LA ☐ LD ☐ LT _____	☐ First ☐ Second	☐ Yes ☐ No

VACCINATOR	NOTES	DATE OF VACCINATION
		/ /

CLINIC LOCATION	CLINIC TYPE	CLINIC ADDRESS	STATE VACCINE SYSTEM DATA ENTRY
			☐ By clinic/agency GIVING vaccine (N) ☐ By clinic/agency NOT giving vaccine (Y)