PRE-REGISTRATION FORM: COVID-19 VACCINE

TO BE COMPLETED BY VACCINE RECIPIENT: KEEP A COPY FOR YOUR RECORDS

Print Name_____DOB_____

Physician Office_____Title:_____
Would you like to take the Covid-19 Vaccine when it is available? Yes____ No____
If you answered no, do not complete this form further. There will be another opportunity to receive the vaccine in the future.

If you answered yes, complete personal information below, to be registered for the vaccine when released, which is required by state law.

Address_____ City_____State_____

Zip Code_____Phone Number_____

Mother's Maiden Name_____
Have you tested positive for COVID19 in the last 90 days: (Circle one) YES / NO

Is there a possibility you are PREGNANT at this time: (Circle one option) YES / NO / N/A

TO BE COMPLETED BY PRE-REGISTRATION TEAM:

ImmTrac#

TO BE COMPLETED BY ADMINISTRATION TEAM:

1st Dose Date_____2nd Dose Due_____

Manufacturer_____ Lot#_____

Expiration Date_____

Injection Site: Deltoid: RIGHT ☐ LEFT ☐

Name of Person Administering Vaccine_____

Signature_____

2nd Dose Date_____

Manufacturer_____ Lot#_____

Expiration Date_____

Injection Site: Deltoid: RIGHT ☐ LEFT ☐

Name of Person Administering Vaccine_____

Signature_____