Information Needed for COVID Vaccination Appointment

Vaccination Clinic Name & Location_____

Date and Appointment Time _____

First Name _____

Middle Initial _____

Last Name _____

Mother's Maiden Name_____

Date of Birth _____

Physical Street Address_____

Street Address City_____

Street Address State_____

Street Address Zip Code_____

County of Address_____

Primary Phone Number_____

Email Address (not required)_____

Race_____

Ethnicity_____

Sex_____

HEALTH CARE WORKER? (YES/NO)

OVER 18 YEARS? (YES/NO)

HISTORY OF SEVERE ALLERGIC REACTION? (YES/NO)

RECEIVED ANY OTHER VACCINES WITHIN LAST 2 WEEKS? (YES/NO)

PREGNANT, BREASTFEEDING OR IMMUNNOCOMPROMISED? (YES/NO)

EXPOSED TO A PERSON WITH COVID-19? (YES/NO)

RECEVIED MOMOCLONAL OR ANTIBODY THERAPY? (YES/NO)

TESTED POSITIVE FOR COVID-19? (YES/NO)