



COVID-19 Vaccination Form

1 PATIENT IDENTIFICATION

Patient Name:	Date of Birth:
Address:	Gender:
City, State, Zip:	Phone #:
Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Black of African American <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Asian <input type="checkbox"/> Other:	Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other:

2 SCREENING QUESTIONS

Have you tested positive for Covid-19 in the last 10 days?
Have you had a past severe allergic reaction to a medication, injectable medication or any other vaccine? If yes, please list your allergies.

3 INSURANCE INFORMATION – PROVIDE COPY TO PHARMACY IF INSURED

<input type="checkbox"/> I receive health insurance from this facility
Social Security # (for those 65+):

4 CONSENT & RELEASE

By completing and signing this form you acknowledge the information is true and correct and you consent to receiving the Covid-19 vaccine. Your signature also authorizes entry of the vaccination(s) into the State Immunization Registry if required.	
Signature:	Today's Date:

VACCINE ADMINISTRATION INFORMATION FOR IMMUNIZER/PHARMACIST ONLY

Administration Date:	Vaccine Manufacturer:	Lot#:
Route: <input type="checkbox"/> Arm <input type="checkbox"/> Leg Site: <input type="checkbox"/> Left <input type="checkbox"/> Right	Date of Last Vaccination:	Patient Temperature:
Immunizer Name & Title:		Immunizer Signature: