Please fill this form out completely. We are unable to administer the vaccine until all the information required is provided. Thank you for your cooperation.

SECTION 1

COVID-19 Vaccine Qualifying Reason, please check all that apply:

☐ Age 75 or older ☐ Age 65 or older

☐ First Responders ☐ Corrections Officers ☐ Food and Agriculture Workers

☐ U.S. Postal Service Workers ☐ Manufacturing Workers ☐ Grocery Store Workers

☐ Public Transit Workers ☐ Education Sector ☐ Childcare Workers

☐ Judiciary (including but not limited to circuit judges, district judges and district attorneys)

INFORMATION ABOUT YOU (PLEASE PRINT)

Name: Last: ____________________________First: ____________________________

Middle Initial: ________

Date of Birth: Month_____ Day______ Year_____ Phone Number: (_______) ____________________

Address: ___________________________ Apt/Room #: ____

City: ____________ State: ______ Zip: _________

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or other
☐ Other Asian ☐ Unknown ☐ Asian ☐ Pacific Islander
☐ Other Nonwhite ☐ Black or African American ☐ White

☐ Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Sex: ☐ Female ☐ Male

Primary Insurance Carrier ID #: ____

Grp #: ________________

Insurance Company: ____________________________

Insurance Company Phone #_____________________

Insured's Name: ____

Relationship: _________________________

Insured's Date of Birth: _____________

Is this the patient's first or second dose of the COVID-19 vaccination?

☐ **First Dose** ☐ **Second Dose**

If second dose, what manufacturer was the 1st dose: _____________________

SECTION 2

COVID-19 SCREENING QUESTIONS: Please check **YES** or **No** for each question.

1. Do you have today, or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea? ☐**Yes** ☐**No**

2. Have you tested positive for/or been diagnosed with COVID-19 infection within the last 10 days? ☐**Yes** ☐**No**

3. Have you had a severe allergic reaction (e.g., needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine? ☐**Yes** ☐**No**

4. Have you had any other vaccinations in the last 14 days (e.g., influenza vaccine, etc.)? ☐**Yes** ☐**No**

5. Have you had any COVID-19 Antibody therapy within the last 90 days (e.g., Regeneron, Bamlanivimab, Convalescent Plasma, etc.) ☐**Yes** ☐**No**

6. Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines, or latex? ☐**Yes** ☐**No**

7. For women, are you pregnant or is there a chance you could become pregnant? ☐**Yes** ☐**No**

8. For women, are you currently breastfeeding? ☐**Yes** ☐**No**

9. Are you immunocompromised or on a medication that affects your immune system? ☐**Yes** ☐**No**

10.Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication? ☐**Yes** ☐**No**