**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.**

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

☐ Age 55 or older ☐ Essential Worker: _______________ (enter type)

☐ First Responders ☐ Food/Grocery/ Agriculture / Manufacturing / Postal workers

☐ 18-54 with health condition ______________ enter condition (must get approval from PCP)

☐ Public Transit Worker ☐ Education Sector ☐ Childcare Workers

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

**INFORMATION ABOUT YOU (PLEASE PRINT) If you do not have insurance write no insurance under Insurance Company. There is no cost to anyone, but we must file with insurance if you have insurance.**

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 second dose of the COVID-19 vaccination? ☐**Yes** ☐**No** manufacturer of the 1st dose: _________________

**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 in 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**