

Recipient Registration and COVID-19 Vaccine Administration Form

Recipient Full Name: _____ Date of Birth ____/____/____

Recipient Email Address: _____ No email

Have you already registered in the COVID-19 Vaccine Portal? Yes No

Home Phone Number: _____ Mobile Phone Number: _____

Address: _____ City: _____

Zip Code: _____ County: _____ State: _____

Best way to contact you: SMS/Text Message Email Both None

Recipient Race: American Indian/Alaska Native Asian Black/African American
 Native Hawaiian or Other Pacific Islander White Other Unknown

Recipient Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Recipient Gender: Male Female Other I do not want to specify

Preferred Language: English Vietnamese Arabic French
 Spanish Hindi Other Decline to state

Disabilities: Not Disabled Cancer Cognitive (Psychological or Psychiatric)
 Neurological Physical (Mobility) Respiratory
 Sensory (Vision or Hearing) Other (Please Specify: _____)

I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an 'applicable Provider'), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

Recipient Signature _____

OFFICE USE ONLY

Verbal Consent for COVID-19 Vaccine Obtained

Site of Injection: Right Deltoid, IM Left Deltoid, IM Other _____

Dose: First Dose Second Dose

Route: Intramuscular Subcutaneous Intradermal

Administration Date: ____/____/____

Administration Time: _____

Vaccine Product: Moderna Pfizer Janssen

Lot #: _____ Exp: ____/____/____

Manufacturer sticker (optional)

Vaccine administered by (Clinician Name): _____ Signature _____

Vaccinating Clinic Name: _____