1st DOSE

Date: _____

Pre-vaccination checklist: _____

_____

First Name: _____ **Last name:** _____

Date of Birth: _____

Email: _____

❑ I do not have an email/I do not wish to disclose this information

What is the name of the organization/place you work for or reside in? _____

Please select your Industry (Please select only one)

Frontline Essential Workers

- ❑ Congregant/Community work
- ❑ Correction workers
- ❑ Education (teachers, support staff, child care)
- ❑ First Responders
- ❑ Food and Agriculture
- ❑ Grocery Store
- ❑ Health Care Provider
- ❑ Manufacturing
- ❑ Public transit
- ❑ US Postal Service

Other Essential Workers (non—frontline)

- ❑ Commercial Facilities (retail, business, entertainment, Lodging)
- ❑ Energy
- ❑ Finance
- ❑ Food Service
- ❑ Governmental Services
- ❑ HealthCare Provider
- ❑ Hygiene Products and Services
- ❑ Industries involving chemicals or hazardous materials
- ❑ IT and Communications
- ❑ Legal
- ❑ Media
- ❑ Public Health
- ❑ Public Safety (engineers)
- ❑ Public safety works and infrastructure support services
- ❑ Shelter and Housing services
- ❑ Transportation and Logistics
- ❑ Water and wastewater

Other Industries

- ❑ College/ University
- ❑ K-12 School
- ❑ Other

Please provide your: Street Address _____

City _____ **County** _____ **Zip Code**_____

_____

State _____ **Home Phone** _____ **Mobile Phone** _____ **Please provide your Street address**

Preferred method of contact

- ❑ Email
- ❑ SMS/Text
- ❑ Both
- ❑ None

Gender:

- ❑ Male

Ethnicity:

- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

Race

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ White
- ❑ Other Race

Are you a member of a state or federal recognized tribal nation? ❑ **YES** ❑ **NO**

If YES, what is the name of the community_____

Do you identify as any of the following?

- ❑ High Risk (Group 1) Healthcare worker
- ❑ Patient-facing Healthcare worker*
- ❑ Frontline essential worker**
- ❑ Other essential worker (non-frontline)
- ❑ Resident of Long Term Care Facility
- ❑ Resident of Congregate/Group Setting
- ❑ Student
- ❑ None of the above

* includes any paid or unpaid healthcare workers with direct patient contact
** defined as first responders, correction officers, food and agricultural workers, US Postal Service workers, manufacturing workers, grocery store workers, public transit workers, workers in the education sector (teachers, support staff), child care workers

Medical Information—Review conditions below that are known to increase risk of severe illness to COVID-19

- Asthma
- Cancer
- Cerebrovascular disease
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease
- Cystic Fibrosis
- Hypertension or high blood pressure
- Type 1 Diabetes Mellitus
- Type 2 Diabetes
- Immunocompromised from solid organ transplant
- Immunocompromised state (weakened immune system)
- Liver disease
- Neurologic conditions, such as Dementia
- Obesity
- Pregnancy
- Pulmonary Fibrosis (having damaged or scarred lung tissue)
- Sickle Cell Disease
- Smoker
- Thalassemia (a type of blood disorder)
- Overweight (BMI >25, but <30)
- Allergies

How many condition (s) from the list above apply to you ? ____None ____One ____2 or more

CONSENT

❑ 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. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determining timing of when the vaccine will be made available to me. **SIGNATURE** _____

Disclosure statement: Life threatening allergic reactions to vaccines are very rare. Signs of an allergic reaction include: shortness of breath, hoarseness or wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes or up to 48 hours after the vaccination. If the recipient is experiencing any of these symptoms, the recipient has been instructed to contact a healthcare provider immediately.

_____**VERBAL CONSENT**: The recipient or legal guardian has been provided the benefits and potential adverse reactions, and provides consent to receive the vaccine.

FOR OFFICE USE ONLY:

Administration Date: _____ Administration Time: _____ ___AM___ PM

Vaccination site:
____ Left Deltoid
_____Right Deltoid

Vaccination Route:
__ Intramuscular

First Dose: _____

Second dose _____

Administered By: _____
Signature and credentials

Print name _____

Revised 1/17/21