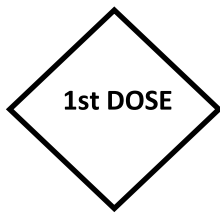

Date: ______________________________

Allergies: ______________________________

____

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
- ❑ Commercial Facilities for Essential Goods
- ❑ Critical Manufacturing
- ❑ Education
- ❑ Food and Agriculture
- ❑ Governmental and Community Services
- ❑ Health Care
- ❑ Public Health
- ❑ Public Safety
- ❑ Transportation

Other Essential Workers (non—frontline)
- ❑ Commercial Facilities (e.g., retail workers, hotel workers)
- ❑ Defense Industrial Base
- ❑ Energy
- ❑ Finance
- ❑ Hygiene Products and Services
- ❑ Industries involving chemicals or hazardous materials
- ❑ IT and Communications
- ❑ Public works and Infrastructure Support Services
- ❑ Residential Facilities, Housing, and Real Estate
- ❑ Water and Wastewater

Other Industries
- ❑ Other / Not Applicable

Please provide your : Street Address ______________________________

City ______________________________ **County** ______________________________ **Zip Code** __________

State __________ **Home Phone** ______________________________ **Mobile Phone** ______________________________

Preferred method of contact
- ❑ Email
- ❑ SMS/Text
- ❑ Both
- ❑ None

Gender:
- ❑ Male
- ❑ Female
- ❑ Other
- ❑ Unknown

Ethnicity:
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

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

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

If YES, what is the name of the communty ______________________________

Do you identify as any of the following?

- ❑ Frontline Essential Worker (in person at work)*
- ❑ Other Essential Worker (non-frontline)
- ❑ Patient-facing Healthcare/Long—Term Care Facility worker**
- ❑ Resident of Long Term Care Facility
- ❑ Resident of Congregate/Group Setting
- ❑ Student
- ❑ None of the above

*defined as first responders, (eg.,firefighters, police officers), 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
**includes any paid or unpaid healthcare workers with direct patient contact

Medical Information—Review the below list of conditions 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 do you have ? ____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 _____

Manufacturer ____________________

Lot Number ____________________

Administered By: ____________________
Signature and credentials

NOTES:

Print name ____________________

Revised 1/27/21