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 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 ☐ Additional 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:_____

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