H.C.H.D. Recipient Registration and COVID-19 Vaccine Administration Form

Recipient Full Name:			
	First	Middle	Last
Date of Birth:/	/Age in Years:		
Recipient Email Address:			\square No email
Have you already registered	in the COVID-19 Vaccine Por	tal? □ Yes	□ No
Home Phone Number:		Mobile Phone Numbe	er:
Address:		City:	
Zip Code:	County:		State:
Best way to contact you:	☐ SMS/Text Message	☐ Email ☐ Bo	oth
Recipient Race:	☐ American Indian/Al☐ Native Hawaiian o	laska Native As r Other Pacific Islander	iian ☐ Black/African American☐ White ☐ Other ☐ Unknow
Recipient Ethnicity:	☐ Hispanic or Latino	☐ Not Hispanic or Lat	ino 🗆 Unknown
Recipient Gender:	☐ Male ☐ Fe	male 🗆 Other	\square I do not want to specify
Preferred Language:	☐ English ☐ Vi	etnamese	☐ French ☐ Decline to state
Disabilities:	☐ Not Disabled ☐ Ca	ncer Cognitive (Psycho	ological or Psychiatric) 🗌 Neurological
patient. Further, I hereby give	piratory Sensory (Vision 8 years of age (b) the parent or my consent to the licensed hea re my personal, demographic	or Hearing) Other legal guardian of the minor palthcare provider administeri	ological or Psychiatric) Neurological (Please Specify: patient; or (c) the legal guardian of the ng the vaccine, as applicable (each an nation in order to provide me with
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Prevaccination Checklist for COVID-19 Vaccination



FOR VACCINE recipients: The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just mean additional questions may be acked. If a question is not clear a clear a skew.	Age ———	
additional questions may be asked. If a question is not clear, please ask you healthcare provider to explain it.	Don' Yes No kno	
1. Are you feeling sick today?		
2. Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product(s) did you receive? □ Pfizer-BioNTech □ Moderna □ Janssen (Johnson &	Another Product	
How many doses of COVID-19 vaccine have you received?		
Did you bring your vaccination record card or other document	tation?	
 Do you have a health condition or are you undergoing treatmen or severely immunocompromised? (This would include treatment for cancimmunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematop or Wiskott-Aldrich syndrome) 	er or HIV, receipt of organ transplant,	
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-COVID-19 vaccine?	cell therapies since receiving	
5. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatmer to ao to the hospital. It would also include an alleraic reaction that caused hives. swelling A component of a COVID-19 vaccine, including either of the following o Polyethylene glycol (PEG), which is found in some medications, succolonoscopy procedures	na. or respiratory distress. includina wheezina.) g:	
o Polysorbate, which is found in some vaccines, film coated tablets, a	and intravenous steroids	
A previous dose of COVID-19 vaccine		
6. Have you ever had an allergic reaction to another vaccine (other or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatmer to go to the hospital. It would also include an allergic reaction that caused hives, swelling.	nt with epinephrine or EpiPen® or that caused you	
7. Check all that apply to you:	· ·	
☐ Am a female between ages 18 and 49 years old	☐ Have a bleeding disorder	
☐ Am a male between ages 12 and 29 years old	☐ Take a blood thinner	
☐ Have a history of myocarditis or pericarditis	$\hfill\square$ Have a history of heparin-induced thrombocytopenia (HIT)	
☐ Have been treated with monoclonal antibodies or convalescent	☐ Am currently pregnant or breastfeeding	
serum to prevent or treat COVID-19	☐ Have received dermal fillers	
□ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection	☐ Have a history of Guillain-Barré Syndrome (GBS)	
Form reviewed by	Date	

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists