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 ☐ Prefer not to answer

Recipient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Recipient Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer

Preferred Language: ☐ English ☐ Vietnamese ☐ Arabic ☐ French ☐ Spanish ☐ Hindi ☐ Other ☐ Prefer not to answer

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/Guardian Signature ____________________

OFFICE USE ONLY

☐ Consent for COVID-19 Vaccine Obtained

Site of Injection: ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐ Other____________

Dose: ☐ First Dose ☐ Second Dose ☐ Additional Dose/Booster

Route: ☐ Intramuscular ☐ Subcutaneous ☐ Intradermal

Administration Date: ____/____/________ Administration Time: ____________

Vaccine Product: ☐ Moderna ☐ Pfizer (12+) ☐ Janssen ☐ Pfizer (PEDS 5-11)

Moderna Dose Amount: ☐ Full Dose (0.50 mL) ☐ Half Dose (0.25 mL)

Lot #: ____________________ Exp: ____/____/______

Vaccine administered by (Clinician Name): ____________________ Signature ____________________

Vaccinating Clinic Name: ____________________

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