COVID-19 Vaccine Registration Form

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	AGE
/ /	

RACE

☐ Alaskan Native ☐ Pacific Islander
☐ American Indian ☐ White
☐ Asian ☐ Other
☐ Black ☐ Unknown
☐ Native Hawaiian

ETHNICITY

☐ Hispanic/Latino
☐ Not Hispanic Latino
☐ Unknown

PATIENT QUESTIONS		
Have you ever had a severe reaction to a vaccine or any injection in the past?	☐ No	☐ Yes
Have you ever had an allergic reaction to a component of a COVID-19 vaccine or a previous dose of COVID-19 vaccine?	☐ No	☐ Yes
Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	☐ No	☐ Yes
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?	☐ No	☐ Yes
Do you have a weakened immune system (ie, from HIV or cancer) or are you on immunosuppressive drugs?	☐ No	☐ Yes
Do you have a history of myocarditis or pericarditis?	☐ No	☐ Yes
Do you have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?	☐ No	☐ Yes
Do you have an history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)?	☐ No	☐ Yes
Do you have a history of thrombosis with thrombocytopenia syndrome (TTS)?	☐ No	☐ Yes
Do you have a history of Guillain-Barré Syndrome (GBS)	☐ No	☐ Yes
Do you feel sick today?	☐ No	☐ Yes

Which dose number? ☐ First dose ☐ Second Dose ☐ Third Dose (Immunocompromised) ☐ Booster Dose

1st dose manufacturer _____ 2nd dose manufacturer _____

1st dose date _____ 2nd dose date _____

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to learn about the benefits and risks (VIS) of the COVID-19 vaccine. Please visit our website (www.hilliardpeds.com) to read our Privacy Policy (PP). By signing below, you agree that 1) you reviewed both the VIS and PP, 2) you understand the benefits and risks of the vaccine and you are asking that the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby consent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record and all information on this form to your state's Immunization Program and the CDC, and 5) we can release this record to your doctor, school, or employer if requested. If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient and the patient on this form may receive vaccine with or without you, as the parent or guardian, present at the time of vaccination. After receiving your vaccine, we recommend you wait at least 15 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time.

PATIENT CONSENT/SIGNATURE (or parent/guardian if patient is age 17 or under)	DATE OF CONSENT
PRINTED NAME	**RELATIONSHIP TO PATIENT**

OFFICE USE ONLY				
DOSE IN SERIES		SITE OF INJECTION		VACCINATOR
☐ First Dose	☐ Third Dose	☐ Left Deltoid	☐ Right Deltoid	
☐ Second Dose	☐ Booster Dose	☐ Left Thigh	☐ Right Thigh	