Site: __________________ Appointment Time: __________________

Essex County Mobile Vaccine Site Registration

PLEASE PRINT SO WE CAN READ YOUR WRITING

Name: ____

Address: ____

City: ______________________ State: ______________ Zip Code: _________________

Email Address: ____

Date of Birth: __________________________Phone: ____________________________

<u>Demographic Information</u>:

Sex: Male Female Unknown Non-Binary

<u>Race</u>: American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Other Pacific Islander White Other Prefer not to specify

<u>Ethnic Group</u>: Hispanic or Latino Not Hispanic Prefer not to specify

Do you have insurance? (please check) Yes___ No___

The Vaccine is free of charge, but your heath insurance will be charged an administration fee.

Insurance Company: ______________________ Insurance Plan: ____________________

Member Policy Number: _____________________ Group Number: _________________

Do you currently have any of the following symptoms; Congestion or runny nose, cough, diarrhea, fatigue, fever of chills, headache, muscle or body aches, nausea or vomiting, new loss of taste or smell, shortness of breath or difficulty breathing, or sore throat? **YES____ NO____**

Have you received ANY Vaccine in the last 14 days? **YES____ NO____**

Have you ever received a COVID-19 vaccine? **YES____ NO____**

Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? **YES___ NO___**

Have you received passive antibody therapy as treatment for COVID-19? **YES____ NO____**

Have you tested positive for COVID-19 in the last ninety (90) days? **YES____ NO____**

Are you pregnant or breastfeeding? **YES____ NO____**

Important Information:

-I give consent to release my vaccination records to the Essex County Health Department

-I give consent to release my vaccination records to the State of New Jersey Immunization Information System.

- I consent to be vaccinated

☐ I agree ____ Date______________

OFFICE USE ONLY:

Vaccine site location: Left Deltoid or Right Deltoid

Lot number: Date: Time:

Vaccinator signature: