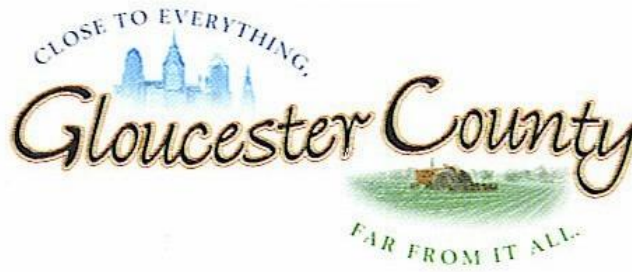


Robert M. Damming
Director

Frank J. DiMarco
Deputy Director

Jim Jefferson
Liaison



Gloucester County
Department of Health

COVID-19 Vaccination Paper Registration Form

Instructions: Please complete the patient information section below and return it to the nurse prior to receiving your vaccination. Please print all information clearly and accurately.

PATIENT INFORMATION

Name (Last, First):

Date of Birth (DOB): _____

Primary Residential Address:

Street

City

State

ZIP

Profession/Job Title:

Phone Number (Where we can best reach you):

Email Address:

Birth Country:

Please indicate if you are a twin, triplet, or quadruplet by checking the box below.

Twin: Triplet: Quadruplet:

Race: White: Black/African American: Asian: American Indian or Alaska Native:

Native Hawaiian or other Pacific islander: Other:

Ethnicity: Hispanic: Non-Hispanic: Prefer not to specify:

Sex: Male: Female:

	YES	NO	DON'T KNOW
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? If yes, which product? _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something?			
4. Have you ever had an allergic reaction to Polyethylene Glycol (PEG), Polysorbate, or a previous dose of covid 19 vaccine?			
5. Were you ever diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID 19 infection?			
6. Do you have a bleeding disorder or are you taking a blood thinner?			
7. Have you received passive antibody therapy as treatment for COVID-19?			
8. Have you received dermal fillers?			
9. Do you have a history of heparin-induced thrombocytopenia (HIT)?			
10. Do you have a weakened immune system or take immunosuppressive drugs (i.e HIV, cancer)?			

I have received the COVID-19 Emergency Use Agreement. I believe that I understand the benefits and the risks of vaccine and request that the vaccine be given to me or the person named above for whom I am authorized to make this request. Print Parent Name: _____ Phone: _____
Parent Signature _____ Date _____

OFFICIAL USE ONLY

Vaccine Manufacturer: Pfizer Moderna Janssen

Dose: First Second *If first dose, date/time second dose scheduled:* _____

Vaccination Site: Right Deltoid Left Deltoid Other _____

Vaccine Lot Number: _____ Vaccine Expiration Date: _____

Vaccine Administered By (Please Print) _____

Signature: _____

Other Notes: _____