Recipient Registration Form

Fields with an * are required

*First Name

*Last Name

*Street Address

*Town/City/State/Zip or Postal Code

Phone Number

Cell Phone

*Gender

- ☐ Female
- ☐ Male
- ☐ Decline to Specify
- ☐ Other

*Date of Birth *Click or tap to enter a date.*

*Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown/Not Reported

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*__Race__ (Please check all that apply)

☐American Indian or Alaska Native

☐Asian

☐Black or African American

☐Native Hawaiian or Other Pacific Islander

☐White

☐Unknown/Not Reported

_____

Emergency Contact Name

_____

Emergency Contact Number

***I am currently living in a nursing home**

☐Yes

☐No

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*Select Priority Group

- ☐Adult with comorbidities or other medical conditions
- ☐Age 65 and older
- ☐Deployed and mission critical personnel for national security
- ☐Education sector personnel
- ☐Emergency service and public safety sector personnel
- ☐Food & agriculture & transportation sector personnel
- ☐Health care providers in long term care facilities (LTCFs)
- ☐Inpatient healthcare providers
- ☐Live with or care for adult 65 and older
- ☐Long term care facility residents
- ☐Manufacturers of pandemic vaccine and other critical pandemic therapeutics
- ☐National Guard personnel
- ☐Other congregate living facility residents
- ☐Other priority groups
- ☐Pharmacists and pharmacy technicians (Retail)
- ☐Public health personnel

_____

*Organization Name

_____

Organization Street Address

_____

Organization City/Town, State, Zip Code

Recipient Medical Questionnaire and Consent

Fields with an * are required

***Are you currently sick?**

- ☐Yes
- ☐No

***Indicate any known allergies**

- ☐Milk
- ☐Fish (e.g. bass, flounder, cod)
- ☐Eggs
- ☐Crustacean shellfish (e.g. crab, lobster, shrimp)
- ☐Peanuts
- ☐Tree nuts (e.g. almonds, walnuts, pecans)
- ☐Wheat
- ☐Soybeans
- ☐Latex
- ☐Gelatin/Egg Protein
- ☐Yeast
- ☐Neomycin
- ☐Other
- ☐No existing or known allergies

***Have you ever had a serious reaction after receiving an immunization?**

- ☐Yes
- ☐No

***Have you ever fainted or felt dizzy after receiving an immunization?**

- ☐Yes
- ☐No

***Are you currently being treated for a long-term health problem such as heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, other blood disorder?**

- ☐Yes
- ☐No

***Are you currently being treated for cancer, leukemia, AIDS or any other immune system problem?**

☐Yes

☐No

***Are you currently taking cortisone, prednisone, other steroids or anti-cancer drugs, or have you had X-ray treatments?**

☐Yes

☐No

***Do you have a history of Guillain-Barre Syndrome?**

☐Yes

☐No

***Have you had a seizure, brain, or nerve problem?**

☐Yes

☐No

***During the past year, have you received a transfusion of blood or blood products, or been given a medicine called Immuna (gamma) globulin?**

☐Yes

☐No

***Are you pregnant or is there a chance you could become pregnant during the next month?**

☐Yes

☐No

List any vaccinations you may have received in the past 4 weeks.

Recipient Medical Questionnaire and Consent

I have read or had explained to me the 2020-2021 Vaccine Information Statement for the COVID-19 vaccine and understand the risks and benefits. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunizations(s) by the person named below for whom I am the legal guardian ("Ward"). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward and each of our respective heirs, executors, personal representatives and assigns, hereby release the provisioning mass vaccination center, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt of my Ward of this or these immunization(s). Neither the provisioning mass vaccination center nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. The provisioning vaccination center will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other healthcare operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward's personal health information.
https://www.cdc.gov/other/privacy.html

☐ **I acknowledge that I have received a copy of the Notice of Privacy Practices.**

_____

Signature

_____

Print: Last Name, First Name (Middle Initial)

_____

State

_____

County

_____

Email Address

Click or tap to enter a date.