COVID-19 Vaccination Registration and Authorization Form

Patient First Name	Middle Name	Last Name	Mother's Maiden Name

Mailing Address ❒ Unhomed Street City State Zip	Primary Phone	Date of Birth (*MM/DD/YYYY*) ❒ Check here if a twin, triplet, etc. / /
Race: *Check All That Apply* ❒ Native Hawaiian ❒ Black/African-American ❒ American Indian/Alaska Native ❒ White/Caucasian ❒ Pacific Islander ❒ Asian	**County of Residence**	**Social Security Number** - -

Ethnicity: *Check One*	Health Insurance: *Check One*	Marital Status:	Parent or Guardian's Full Name (Age Under 18 Years)
❒ Hispanic or Latino ❒ All others	❒ Private/Commercial ❒ Medicaid ❒ Medicare ❒ CHIPS ❒ Any Other ❒ None	❒ Single ❒ Married ❒ Divorced ❒ Widowed	

My Emergency Contact Person

Full Name	Address (City, State, Zip)	Relationship	Contact Phone Number

I hereby authorize and give permission to NMPHC and its employees to provide such medical, dental and/or behavioral treatment as may be deemed necessary for the patient named above.

Patient/Guardian Signature _____ **Date** _____

Vaccination Health Questionnaire: *(If you answer "Yes" to a question, you still may be able to be vaccinated today)*

1. Are you feeling sick today? ❒Yes ❒No ❒Don't know

2. Have you ever received a dose of COVID-19 vaccine?
   - If yes, which vaccine product did you receive?
   ❒Pfizer ❒Moderna ❒Janssen *(Johnson & Johnson)* ❒Another Product
   - Did you bring your vaccination record card or other documentation? ❒Yes ❒No

3. Have you ever had an allergic reaction to: ❒Yes ❒No
   (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)

• A component of a COVID-19 vaccine, including either of the following: ○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures ○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	• A previous dose of COVID-19 vaccine

4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? ❒Yes ❒No
   (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)

5. Check all that apply to you:
   ❒ Am a female between ages 18 and 49 years old
   ❒ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
   ❒ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
   ❒ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
   ❒ Have a weakened immune system (i.e., HIV infection, cancer)
   ❒ Take immunosuppressive drugs or therapies
   ❒ Have a bleeding disorder
   ❒ Take a blood thinner
   ❒ Have a history of herparin-induced thrombocytopenia (HIT)
   ❒ Am currently pregnant or breastfeeding
   ❒ Have received dermal fillers