Quick Registration Form

Please Print Legibly

1. **Last Name**: _____ **First Name:**_____
2. **Birth Date**:_____/_____/_____ **Mothers First Name**:_____
3. **Are you a vet?** ☐ Yes ☐ No
4. **What is your gender?**

   ☐ Female ☐ Male ☐ Trans Female to Male ☐ Trans Male to Female

   ☐ Other ☐ Prefer Not to Answer ☐ Do not know

5. **What is your Sexual Orientation?**

   ☐ Heterosexual (Straight) ☐ Gay ☐ Lesbian ☐ Bi-Sexual

   ☐ Other:_____ ☐ Prefer not to answer ☐ Do Not know

5. Race/Ethncity:_____

6. Email:_____ ☐ I Do Not Have Email

7. Best Phone Number: (____) _____-_____ ☐ I Do Not Have A Phone Number

☐ Homeless

Street Address:_____ City:_____ State:_____ Zip Code:_____

8. Insurance Information

Do You Have Health Insurance? ☐ YES ☐ NO
If Yes Please Check One: ☐ Medi-Cal ☐ Medi-Care ☐ Private Insurance
Insurance Carrier:_____ Policy Number:_____
Group Number:_____

9. Income Information:_____Yearly/Monthly/Weekly/Bi-Weekly

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COVID-19 Vaccine Consent Form

Medical History	Yes	No	Don't know
Do you have allergies to latex, food, medications, or vaccine components? (Such as eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein)?	○	○	○
Have you ever experience any serious reaction after getting a vaccine?	○	○	○
In the past year, did you receive a transfusion of blood or blood products, or injected immune (gamma) globulin or any antiviral drug?	○	○	○
Have you had any brain or other nervous system problems?	○	○	○
Are you pregnant or planning to get pregnant or your partner is planning to get pregnant?	○	○	○

- **Do you have any of the followings? (Select all that apply)**
  - ○ Lung Disease
  - ○ Heart Disease
  - ○ Asthma
  - ○ Kidney Disease
  - ○ Diabetes
  - ○ Anemia
  - ○ Blood Disorder
  - ○ Autoimmune Disorder
  - ○ None of the above

- Do you have immunocompromised condition?(Select all the apply)
  - ○ Cancer ○ Transplant ○ None of the above
  - ○ Leukemia ○ Asplenia
  - ○ Lymphoma ○ CSF Leak
  - ○ HIV/AIDS ○ Cochlear Implant
- **Have you ever tested positive for COVID-19?**
  ○ Yes ○ No

- **In the last 14 days, have you had any contact with a person who was confirmed to have COVID-19?**
  ○ Yes ○ No

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COVID-19 Vaccine Consent Form

- **In the last 14 days have you traveled internationally?**
  ○ Yes ○ No

- **Do you have any of the following symptoms?**
  ○ Cough ○ Shortness of breath
  ○ Cold ○ Sore Throat
  ○ Fever ○ abdominal pain/diarrhea
  ○ Loss of smell/taste ○ None
  ○Abnormal bruising or bleeding/eye redness

- **Personal Information**

  First Name: _____ DOB: _____/_____/_____

  Last Name: _____ Phone number: ( ) -

- **Address**
  Street name: _____ State: ____

  City: _____ Zip: _____ County: _____

CONSENT

By signing this form, I hereby accept that I have read and understood the acknowledgment letter provided above.
I declare that the information I have provided above is correct.
I am giving my full consent to get the COVID-19 vaccine of my own will.

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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