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: _____

Demographic Information:

Sex: ☐Male ☐Female ☐Unknown ☐Non-Binary

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American

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

Ethnic Group: ☐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: