**Registration and Pre-vaccination Questionnaire:**

**Please complete all sections before going to the clinic. Please print clearly.**

| | | | | |
|---|---|---|---|---|
| First name (given name) | | | | |
| Last name (family name) | | | | |
| Gender (mark with an X) | Male | Female | Unknown/ Unreported | Other |
| Date of Birth | _____/_____/_____ | | | |
| Are you Hispanic / Latino? | Yes | No | Don't Know/ Unreported | |
| Race (check all that apply) | American Indian or Alaska Native | Asian | Black or African American | |
| | Native Hawaiian or Pacific Islander | White | Unknown/ Unreported | |
| Home address: Street | | | | |
| Home address: City | | | | |
| Home address: State | | | | |
| Home address: Zip Code | | | | |
| Email address: | | | | |
| Phone number: | | | | |

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Age 18 or older _____
Verbal parental consent _____
Signed consent form (if parent/guardian not present) _____

GREATER SEACOAST COMMUNITY HEALTH

STRAFFORD COUNTY PUBLIC HEALTH NETWORK

| Screening Questions | Yes | No |
|---|---|---|
| Are you feeling sick today? | | |
| **Have you ever received a dose of a Covid-19 Vaccine?**<br>If yes, which one? (circle one)<br>Pfizer Moderna Johnson&Johnson<br>*Date of first vaccine:* _____ | | |
| Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including **polyethylene glycol (PEG**), which is found in some medications, such as laxatives and preparations for colonoscopy procedures | | |
| Have you ever had an allergic reaction to **polysorbate**? | | |
| Have you ever had an allergic reaction to a **previous dose of a Covid-19 vaccine**? | | |
| Have you ever had an allergic reaction to **another vaccine** (other than COVID-19 vaccine) or an injectable medication? | | |
| Have you ever had a severe allergic reaction (e.g., **anaphylaxis**) to **something other than a component of COVID-19 vaccine**, polysorbate, or any vaccine or injectable medication?<br>This would include food, pet, environmental, or oral medication allergies. | | |
| Have you received any vaccine in the last 14 days? | | |
| Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? | | |
| Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | | |
| Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | | |
| Do you have a bleeding disorder or are you taking a blood thinner? | | |
| Are you pregnant or breastfeeding? | | |

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Vaccinator: Write lot number here when vaccine administered_____

IF VACCINE NOT ADMINISTERED MARK HERE _____