NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

COVID-19 Recipient Vaccination Questionnaire

PERSONAL AND CONTACT INFORMATION

Please fill out ALL the information below

First Name: _____ **Last Name:** _____

RISK LEVEL INFORMATION

Are you responsible for caring/cleaning in areas with COVID Patients?

- ☐ Yes
- ☐ No

Are you responsible for performing tasks with high risk of aerosolization (intubation, bronchoscopy, suctioning, invasive dental procedures, invasive specimen collection, CPR)?

- ☐ Yes
- ☐ No

Are you responsible for handling decedents with COVID?

- ☐ Yes
- ☐ No

Are you planning to be responsible for administration of the Vaccine?

- ☐ Yes
- ☐ No

Insurance Information (if applicable):

Provider _____

ID# _____

Group # _____

For Provider: If Recipient answers Yes to any of these questions, please enter Risk = High. If No to all question, please enter Risk = Low

What is the name of the organization you work/reside in? _____

What is the type of organization listed above? (Please Select One):

- ☐ Public Health Department
- ☐ Family or Internal Medicine
- ☐ Geriatric Medicine
- ☐ Hospital
- ☐ Pediatrician
- ☐ STD/HIV Services
- ☐ Urgent Care
- ☐ Long-Term Care Facility
- ☐ Family Planning
- ☐ Pediatrician
- ☐ Pharmacy
- ☐ Other Health Care Facility
- ☐ Home / Personal / Community Aid
- ☐ Dentist
- ☐ Homeless or Crisis Care
- ☐ CHC / FQHC / RHC
- ☐ Group or Congregate Living
- ☐ Migrant or Refugee Services
- ☐ Mortician / Funeral Home
- ☐ Childcare / School / College
- ☐ Prison
- ☐ Emergency Services
- ☐ Government Agency
- ☐ Religious Organizations
- ☐ Tribal or Indian Health Services
- ☐ Retail / Grocery
- ☐ Food Processing, Preparation, or Serving
- ☐ Transportation
- ☐ Manufacturing / Farming
- ☐ Construction
- ☐ Other

For Provider: If Specific Employer cannot be found in CVMS, Select Generic Version of Above Employer Type as Employer

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Do you work or reside in the organization listed above?

- ☐ Work
- ☐ Reside
- ☐ Both

For Provider: If Work or Both chosen, please select Type = Employee. If Reside Chosen = Individual

Date of Birth: _____

Email:_____

- ☐ I do not have an email/ I do not wish to disclose this information

Street: _____

City: _____ **County:** _____

State: _____**Zip Code:** _____

Home Phone: _____ **Mobile Phone:** _____

Communication Preference:

- ☐ Email
- ☐ SMS
- ☐ Both
- ☐ None

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Other

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Gender:

- ☐ Male
- ☐ Female
- ☐ Unknown

Are you an Essential Frontline Worker (Police, Food Processing, Teachers, etc.)?

- ☐ Yes
- ☐ No

If yes, what is the name of your employer? _____

Do you reside or work in a long-term care/assisted living facility?

- ☐ Yes
- ☐ No

If yes, what is the name of the facility?_____

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Are you a member of a state or federal recognized tribal nation?

☐ Yes
☐ No

If yes, what is the name of the community?_____

MEDICAL INFORMATION

Review the below list of conditions known to increase risk of severe illness to COVID-19:

- Asthma
- Cancer
- Cerebrovascular Disease
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease
- Cystic Fibrosis
- Hypertension or High Blood Pressure
- Type 1 Diabetes Mellitus
- Type 2 Diabetes
- Immunocompromised from solid organ transplant
- Immunocompromised state (weakened immune system)
- Liver Disease
- Neurologic conditions, such as Dementia
- Obesity
- Overweight (BMI > 25 kg/m2, but < 30 kg/m2)
- Pregnancy
- Pulmonary Fibrosis (having damaged or scarred lung tissues)
- Sickle Cell Disease
- Smoker
- Thalassemia (a type of blood disorder)

How many conditions known to increase risk of severe illness from COVID-19 do you have?

☐ None
☐ 1
☐ 2 or more

CONSENT

☐ I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available to me.

_____

Signature of Recipient