# Recipient Registration and COVID-19 Vaccine Administration Form

**Recipient Full Name**: ________________________________________________ **Date of Birth** _____/_____/______

**Home Phone Number:** ____________________________ **Mobile Phone Number:** ___________________________

**Address:** _______________________________________________ **City:** __________________________________

**Zip Code:** _________________ **County:** _______________________________________ **State:** _______________

**Recipient Email Address:** _____________________________________________________ ☐ No email

**Have you already registered in the COVID-19 Vaccine Portal?** ☐ Yes ☐ No

**Best way to contact you:** ☐ SMS/Text Message ☐ Email ☐ Both ☐ None

**Recipient Race:** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

**Recipient Ethnicity:Recipient** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

**Gender**: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify

**Preferred Language:** ☐English ☐ Spanish ☐ Vietnamese ☐ Arabic ☐Hindi ☐French ☐Decline to State ☐Other

**Please check all disabilities that apply to you:**

☐ Not Disabled
☐ Cancer
☐ Cognitive
☐ Neurological
☐ Physical
☐ Respiratory
☐ Sensory (Vision or Hearing)
☐ Other (Please Specify) _________________

☐ **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.

**Recipient Signature** ______________________________________________________________________________

**THE VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NOINSURANCE AT ALL.**
**If you have your insurance card with you today please fill out the insurance information.**

Insurance Name: ___________________________________ Member ID: ______________________________________

Group Number: ___________________________________

Subscriber Name: ______________________________________ Subscriber Date of Birth: _____/_____/________

☐ I authorize payment from 3rd Party Payer (Insurance) and Medicare/Medicaid be made on my behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature above will serve as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to the licensed healthcare provider administering the vaccine for services rendered.

## OFFICE USE ONLY

☐ **Verbal Consent for COVID-19 Vaccine Obtained**

**Site of Injection:** ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐Other________________

**Dose:** ☐ First Dose ☐ Second Dose

**Administration Date:**

**Administration Time:** ____________________

**COVID-19 Vaccine Manufacturer:**

**Exp:**__/_____/_______

**Shot administered by:**

| Rhonda | Ryanne |
|---|---|
| Lisa | Kim |
| Luann | EMT |
| Christina | Other |
| Heather | |

**Vaccine administered by (Clinician Name)**_________________________ **Signature**___________________________

**Vaccinating Clinic Name**______________________________________________________________________