

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 health 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: _____