DATE:_______________

ARM VACCINATED: Right Left

Is this your (circle one):

1st Dose 2nd Dose **Bivalent Booster**

COVID VACCINE REGISTRATION

PLEASE PRINT CLEARLY.

Information as on drivers license:

Legal Last Name ______________ Legal First Name: ______________ Date of Birth : _____/_____/_____

Gender: Female Male Other ______ Address: ______________________

City: ______________ State: ______________ Zip Code: ______________

Mobile Phone: ( ) - ______________ Do you accept Texts on this phone #? Y N

E-Mail Address: ______________________

Race: Asian Black Other White Ethnicity: Hispanic Non-Hispanic Marital Status: Married Single Other

Insurance: Yes No

If yes, name of Company:________________________________ Member ID#:________________________________

If no, Drivers License #/State: ______________________ or SSN:______________________

By signing, you have read the COVID Vaccine Fact Sheet, acknowledging understanding and are consenting to receive the vaccine. You are also consenting to having your data reported to the Texas ImmTrac2 Registration and to file an administrative fee to your insurance or HRSA.gov. In order for us to receive this vaccine to give you from the State, we are *required* to report to the Texas Registry ImmTrac2. If you still have any questions, do not sign below, please ask for someone to answer your questions.

X

Patient Signature / Parent or Legal Guardian of Patient

Date

Admin ONLY: Given By:

Initials:___________Fact Sheet Y N

Name Printed:______________________________