DATE:____________________ ARM VACCINATED: R L

Is this your (circle one):

1st Dose 2nd Dose 3rd Dose

COVID VACCINE REGISTRATION

PLEASE PRINT CLEARLY.

Legal Last Name: ____________________ **Legal First Name:** ____________________ **Date of Birth:** _____/_____/______

Gender: Female Male Other **Address:** ____________________

City: ____________________ **State:** ____________________ **Zip Code:** ____________________

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

E-Mail Address: ____________________

Race: Asian Black Other White **Ethnicity:** Hispanic Non-Hispanic

Do you work in a School or Childcare facility: Y N

Have you had a Influenza or Shingles Vaccine in the past 2 weeks: Y N

Insurance: Yes No

If yes, name of Company:__________________________________**Member ID#:**____

If no, Drivers License #/State:__________________________________**or SSN:**____

By signing, you are 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.

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Patient Signature / Parent or Legal Guardian of Patient **Date**