COVID-19 VACCINE BOOSTER PRE-REGISTRATION FORM

Pre-Registration Questions

For Questions 1,2,3, and 4, 5 select your response in the boxes on the right.
For Questions 5, write in the date or "none" as applicable

1.	Have you been tested for COVID-19 at the Sedgwick County Health Department within the last year?	Yes	No
2.	Have you received COVID-19 vaccine at the Sedgwick County Health Department?	Yes	No
3.	Have you received COVID-19 vaccine at a location other than Sedgwick County Health Department?	Yes	No
4.	Are you fully vaccinated (one dose of J&J, two doses of Pfizer or Moderna)?	Yes	No
5.	If you have received COVID-19 vaccine, what was the date of your last shot? _____ (estimated date or "none")		

Relationship to Client: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

CLIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ Gender: ☐ Female ☐ Male ☐ Other _____

Race ☐ African American/Black ☐ Asian ☐ Native American ☐ Other
☐ Hispanic ☐ White ☐ Middle Easterner ☐ Pacific Islander

Hispanic ☐ Yes ☐ No Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other

Street Address: _____

County: _____ State: _____ ZIP Code: _____

City: _____ Phone: _____

Email: _____

Consent to Contact:

Consent to call? ☐ Yes ☐ No

Consent to text? ☐ Yes ☐ No

If the client is under 18 or client has a guardian, Parent or Guardian complete this section)

Last Name: _____ First Name: _____ Middle Initial: _____

Email: _____ Cell Phone: _____ Other Phone _____

PATIENT COVID-19 PRE-VACCINATION QUESTIONARE (COMPLETION REQUIRED)

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.
If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Are you experiencing moderate to severe illness and/or a fever?	☐ Yes ☐ No
Have you received any type of vaccine within the past 14 days? If so what kind _____	☐ Yes ☐ No
Have you received passive antibody therapy (monoclonal antibodies or convalescent plasma) as part of COVID-19 treatment within the past 90 days?	☐ Yes ☐ No
Are you pregnant?	☐ Yes ☐ No ☐ N/A
Are you currently breastfeeding?	☐ Yes ☐ No ☐ N/A
Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No
Do you have a weakened immune system caused by something such as HIV infection or cancer or are you taking a drug that weakens your immune system?	☐ Yes ☐ No
Allergies:	

Patient Signature: _____ Date: _____

Sedgwick County... working for you