Southwest Nebraska Health Department
COVID-19 VACCINE REGISTRATION FORM

Last Name	Legal First Name	MI	Maiden Name	Mothers Maiden name

Address	City	State	Zip

Phone (____) _____ - _____	E-Mail address	Name of Physician

Gender: ☐ Male ☐ Female	Date of Birth _____/_____/_____	Age

For private insurance (policy holder information)

Race:
- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other pacific Islander

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Insurance Company:

_____

Policy Holder Information

Name:

_____

Date of Birth____/____/_____

Insurance Status:
- ☐ Private Insurance covers immunizations
- ☐ Private Insurance does NOT cover immunizations
- ☐ Medicaid/Medicare
- ☐ American Indian / Alaska Native
- ☐ No Insurance

Client Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Other

Answer the Following Client Health Questions	DOSE 1		DOSE 2	
1. Are you sick today?	☐Yes	☐No	☐Yes	☐No
2. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen® for which you had to go to hospital?	☐Yes	☐No	☐Yes	☐No
3. Was the severe allergic reaction after receiving a COVID-19 vaccine?	☐Yes	☐No	☐Yes	☐No
4. Was the severe allergic reaction after receiving another vaccine or another injectable medication?	☐Yes	☐No	☐Yes	☐No
5. Are you immunocompromised? (immune system weakened)	☐Yes	☐No	☐Yes	☐No
6. Do you have bleeding disorder or are you taking a blood thinner?	☐Yes	☐No	☐Yes	☐No
7. Have you received passive antibody therapy as treatment for COVID-19? (BAMlam)?	☐Yes	☐No	☐Yes	☐No
8. For women only: If you are currently pregnant, breastfeeding or wanting to get pregnant, have you talked with your provider prior to being vaccinated?	☐Yes	☐No	☐Yes	☐No

I have read and/or received a copy of the vaccination fact sheet for the COVID-19 vaccination which I or the person for whom I have filled out this form have received.

_____ _____

SIGNATURE of person receiving shot or Parent/Guardian (1st Dose) DATE

_____ _____

SIGNATURE of person receiving shot or Parent/Guardian (2nd Dose) DATE

Revision 9/6/2021

To be completed by staff:

DOSE ONE

Manufacturer:	Lot #:	Exp Date:
Injection Site (circle one): Left Deltoid Right Deltoid Other (specify) _____	Dosage: Route: IM Other (specify) _____	
_____ Signature of Vaccine Administrator	_____ Date of Vaccine Administration	

DOSE TWO

Manufacturer:	Lot #:	Exp Date:
Injection Site (circle one): Left Deltoid Right Deltoid Other (specify) _____	Dosage: Route: IM Other (specify) _____	
_____ Signature of Vaccine Administrator	_____ Date of Vaccine Administration	

Dose 1: ☐ NESIIS ☐ Ins. Billed: ____/___/_____ _____ ☐ QB: **Dose 2:** ☐ NESIIS ☐ Ins. Billed: ____/___/_____ _____ ☐ QB: