Indiana Department of Health

COVID-19 Vaccination Patient Intake Form

First Name | MI | Last Name | DOB | Mobile Phone

Address | Email

City | State | Zip Code | Gender | Pregnant?

☐ M ☐ F ☐ Y ☐ N

Preferred Language:

- English
- Spanish
- Other
- Prefer not to Say

Preferred Ethnicity:

- Hispanic or Latino/Spanish
- Non-Hispanic or Latino/Spanish
- Prefer not to Say

Preferred Race:

- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other Race
- Prefer not to Say

Is the patient sick today?

☐ Y ☐ N

Does the patient have allergies to medications, food, a vaccine component, or latex?

☐ Y ☐ N

Has the patient ever had a serious reaction after receiving a vaccination?

☐ Y ☐ N

Primary Medical Insurance Carrier

Policy Number

Group ID (If Present)

Policy Holder

PARENT CONSENT FOR COVID-19 VACCINATION OF STUDENTS YOUNGER THAN 18

Signature: | Date:

Notice of Privacy Practices

Signature: | Date:

Vaccine Information (Only for office personnel use)

Vaccine Name | VIS/EUA Date | Dosage

CXV Code | Expiration Date | Administering Facility

Lot Number | Administration Site | Administration Date

Manufacturer | Administration Route

Indiana Department of Health — Division of Immunization