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 ☐ M ☐ F | Pregnant? ☐ 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

Employer Name

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

Risk Factors (Circle all that apply)
- Obesity
- Over 65
- Diabetes
- Chronic Kidney Disease
- COPD
- Serious Heart Condition
- Sickle Cell Disease
- Other

Reason for Vaccination (Circle all that apply)
- Health Care Worker
- Long Term Care Employee
- Long Term Care Resident

Primary Medical Insurance Carrier

Policy Number

Group ID (If Present)

Policy Holder

PATIENT CONSENT FOR COVID-19 VACCINATION

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