Long Beach Island Health Department
2119 Long Beach Blvd., 1st Floor
Ship Bottom, NJ 08008
609-492-1212

COVID Vaccination Registration Form

Name:	DOB:
Address:	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Non-Binary
Phone:	
Email	
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Prefer Not to Specify	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic ☐ Prefer not to Specify

Pre-Immunization Questionnaire	**Yes**	**No**
Do you have any known or severe Allergic reaction to any vaccine?		
Do you have any Bleeding Disorders or on Blood Thinners		
Does the person receiving the vaccine have a fever of ≥100 Degrees F?		
Did you receive Passive Antibody therapy in the past 90 days?		
Are you considered an Immunocompromised patient		
Have you received another vaccine in the last 14 days?		

Patient Signature: _____

I have read, or have had explained to me, the CDC Emergency Use Authorization Form about the Janssen/Johnson & Johnson or the Moderna Vaccine. I acknowledge that I have been given the opportunity to review the LBI Health Notice of Privacy Practices on this date. I understand that this vaccine may cause symptoms in some people but will not actually cause the Covid Virus. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of Covid vaccine and request that the vaccine be given to me or for whom I am authorized to make this request. I have answered all questions truthfully and accurately. I request that payment of authorized Insurance benefits be made to me or on my behalf to the Long Beach Island Health Department for any services furnished to me by the LBI Health. I authorize any holder of medical information about me to release to the insurance carrier of record and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____ Date:_____

Medicare # (If applicable): _____

No out-of-pocket expense for vaccine, Medicare information is requested to help offset the cost of providing this service to you as the resident.

Below for nurse use only:

Dose: 1st_____ 2nd_____ Manufacturer: _____ Rout: Deltoid _____L _____R

Signature of Nurse: _____ Date:_____