

COVID VACCINE REGISTRATION FORM

Pleas	e circle	Yes or No for the	following question	ons. Are you	ı:		
Υ	N	An agricultural work	ker	Υ	N	School Based Health student	
Υ	N	Homeless		Υ	N	Living in public housing	
Sexua	al Orien	itation:					
	Lesbian, gay or homosexual			Something else, please describe:			
	Straight or heterosexual			Don't know			
	Bisexual			Choose not to disclose			
profes	ssionals	, nurses, and technicians	involved in care of	f the patient a	above to	es (WYH), staff physicians, allied health o administer COVID 19 vaccination services	
and to	perior	m such treatment or pro	cedures that are n	ecessary in tr	ie norm	al course of providing these services.	
Patient Name				Patient Date of Birth			
Legal Guardian Name (if applicable)				Relationship to Patient			
Signature of Patient or Legal Guardian				Signature Date			
	Witness Name		Witness Signature			Witness Date	