COVID-19 VACCINATION REGISTRATION FORM

Please complete this form in its entirety prior to arriving for your vaccine.

Name: ____
(FIRST) *(MIDDLE)* *(LAST)*

Date of Birth: _________________ **Birth Location:** ______________________________________
(MM/DD/YY) *(COUNTRY, STATE)*

Full address: ____
(STREET NUMBER AND STREET) (APARTMENT/UNIT#)

____
(CITY) *(STATE)* *(ZIP CODE)*

Phone: _____________________________ **Primary Care Provider:** ___________________________
(HOME/CELL)

Gender: ____________________________ **Ethnicity:** ______________________________________
(AS ASSIGNED AT BIRTH) *(HISPANIC/LATINO; OR NOT HISPANIC/LATINO)*

Race: ____
(AMERICAN INDIAN/ALASKA NATIVE; ASIAN; BLACK/AFRICAN AMERICAN; HISPANIC/LATINO; HAWAIIAN NATIVE/OTHER PACIFIC ISLANDER; WHITE/CAUCASIAN; OTHER- SPECIFY)

Emergency Contact: ____
(NAME) *(PHONE NUMBER)*

The requested information on this form is required for documenting vaccine administration in I-CARE (the Immunization Information System for the state of Illinois) as required by the CDC.