___ Moderna Vaccine
___ Johnson Vaccine
___ Pfizer

GARLAND
PUBLIC HEALTH

COVID-19 Vaccine Registration Form

I understand that the City of Garland Health Department complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Rule. I understand that the City of Garland Health Department maintains the privacy of Patient's information in accordance with federal and state laws.

Patient Information:

Last Name:_____ **First Name:**_____ **Middle Name:** _____

Date of Birth:_____ **Male:** ☐ **Female:** ☐

Address:_____ **Apt. #**_____ **City:**_____ **State:**_____ **Zip:** _____

Contact Phone Number:_____ **Email:** _____

_____ _____
Mother's First Name **Mother's Maiden Name**

Eligibility:

- ☐ **First Responder**
- ☐ **School or Childcare Employee**
- ☐ **Employee: Garland, Rowlett, Sachse**
- ☐ **Other**

Race: (Please choose one)

- ☐ **American Indian or Alaska Native**
- ☐ **Asian**
- ☐ **Black or African American**
- ☐ **Native Hawaiian or Other Pacific Islander**
- ☐ **White**
- ☐ **Unknown**
- ☐ **I do not wish to answer**

Ethnicity: (Please choose one)

- ☐ **Hispanic or Latino**
- ☐ **Not Hispanic or Latino**
- ☐ **I do not wish to answer**

Clinical Use Only

Date	Vaccine	Lot No.	Site	1st or 2nd dose?

Date entered into Immtrac2:_____ **Initials:** _____