Government of the Republic of Trinidad and Tobago
Ministry of Health

CONFIDENTIAL

COVID-19 Vaccination Pre-Registration Form - **2nd Dose**

1. BIODATA *(To be completed by Applicant in capital letters)*

Vaccination Site

Identification No.

Identification Type

ID ☐ DP ☐
BP ☐ PP ☐

Last Name

First Name

Other

Contact Number

Date of Birth (dd/mm/yyyy)

Gender

Male ☐ **Female** ☐

FOR OFFICIAL USE ONLY *(To be completed by Screening or Administering Nurse)*

2. PRE-VACCINATION SCREENING

	Yes	No	Details
Do you have any flu-like symptoms today? e.g. fever, dry cough			
Is this your second dose of COVID-19 vaccine?			
Have you ever had a confirmed allergic reaction to the first dose of the COVID-19 vaccine?			
Did you contract the COVID-19 virus after your first shot? If yes, what date?			
Do you have any questions about your vaccination today?			
Do you consent to receiving the COVID-19 vaccine?			
Are you currently pregnant?			
What is the brand of your first dose of COVID-19 vaccine?			

3. VACCINATION INFORMATION

Name of Vaccine, Expiry, Batch No.

Vaccine Name:

Batch #

Expiry Date:

Vaccinated By (Name):

Vaccinated By (Signature):

Date Vaccine Administered:

Immunization Card Updated: ☐

Adverse Reaction

Yes ☐ **No** ☐

Description of Event

Time In:

Time Out:

Discharged By (Name):

Discharged By (Signature):