UWI ID#: TEMPERATURE:

STUDENT VISITOR STAFF

FOR OFFICAL USE ONLY: PLEASE CIRCLE THE APPROPRIATE CATERGORY

COVID-19 Vaccination Pre-Registration Form

Date

Location

Identification Type

ID **DP**

BP **PP**

Last Name

First Name

Other

Gender

Male **Female**

Identification No.

Date of Birth (dd/mm/yyyy)

Age

Address

Contact No./ email

Next of Kin

Nationality

Next of Kin Contact

Are you a Health Care Worker? Yes **No**

If yes, please state profession

Place of Work

Pre-Vaccination Screening

	Yes	No	Details
1. Are you well today?			
2. Do you have flu-like symptoms? Eg. Runny nose, fever			
3. Do you have any medical conditions that we should be aware of? Eg. Diabetes Mellitus, Hypertension (If yes, state in details)			
4. Have you received any other vaccination in the last 2 months? (If yes, state in details)			
5. Do you have allergies? Eg. Seafood, eggs, antibiotics (If yes, state in details)			

NURSE'S VITALS:

BP: **P:** **SPO2:**

	Yes	No	Details
6. Have you ever had a confirmed allergic reaction to the first dose of the COVID-19 vaccine?			
7. Are you currently pregnant?			
8. Are you currently breastfeeding?			
9. Have you tested positive for coronavirus infection within the last 6 months?			
10. Do you have a bleeding disorder, or are you currently taking or have recently stopped taking Warfarin?			
11. Do you have any questions about your vaccination today?			
12. Do you consent to receiving the COVID-19 vaccine?			

Vaccination Information

Name of Vaccine **Expiry Date** **Batch No.**

Observation

Time In:

Time Out:

Immunization Card Issued

Next Appointment Date

Adverse Reaction

Yes **No**

Description of Event

Nurse's Signature