WHITNEY YOUNG HEALTH

HEALTHCARE DESIGNED AROUND

COVID VACCINE REGISTRATION FORM

Please circle Yes or No for the following questions. Are you:

Y	N	An agricultural worker	Y	N	School Based Health student
Y	N	Homeless	Y	N	Living in public housing

Sexual Orientation:

_____	Lesbian, gay or homosexual	_____	Something else, please describe:
_____	Straight or heterosexual	_____	Don't know
_____	Bisexual	_____	Choose not to disclose

By signing this form, you give consent to Whitney M. Young, Jr. Health Services (WYH), staff physicians, allied health professionals, nurses, and technicians involved in care of the patient above to administer COVID 19 vaccination services and to perform such treatment or procedures that are necessary in the normal 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