AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

Date: _____

COVID-19 Vaccination - Disqualification Form

Location: _____

Demographic Information

Hispanic, Latino, or Latina? (check one)
☐ Hispanic ☐ Not Hispanic

Race (select all that apply)
☐ Asian, including South Asian
☐ Black, including African American or Afro-Caribbean
☐ Native American or Alaska Native
☐ Native Hawaiian or Pacific Islander
☐ White
☐ I do not identify as any of these races

Specific ethnic or cultural group(s):

Gender identity (check one)
☐ Male ☐ Female
☐ Other

Appointment #:

Last Name

First Name

Street Address

City **State**

Zip Code **Date of Birth** MM/DD/YYYY **Age**

Phone Number **Marital Status** ☐ M ☐ S ☐ D ☐ W

Patient/Guardian Email:

Emergency/Guardian- Name **Emergency/Guardian- Number**

Company Name **Company Location**

Screening
☐Completed
☐Not Completed

Walk-In
☐Yes
☐No

Disqualifying Reason
☐Acute Illness
☐Monoclonal Antibody within past 90 days
☐COVID Diagnosis within past 10 days
☐Isolation due to exposure within past 10 days
☐Severe Allergy to same type of COVID vaccine
☐Age ineligible
☐State/City Registry Discrepancy
☐Other _____

Staff/Clinician Full Name: ☐RN ☐Other _____ **Date:**

Staff/Clinician Signature: