Intake Form

Princeton Fire/EMS COVID 19 Vaccination Program Red bordered fields are required.

1. Are you feeling ill today (yes/no)?
2. Have you ever had a reaction to any vaccine(yes/no)?
3. Are you positive to COVID-19 today(yes/no)?
4. Have you received monoclonal antibody treatment in the last three months (yes/no)?

We are making you aware that if you are immunocompromised that you may not achieve immunity to COVID-19 after the shot.

Last name:

First name: Middle name:

Date of Birth (MM/DD/YYYY):

Gender:

Phone #:

Allow Data Sharing (yes/no)? (Most people choose "yes.")

Data sharing indicates that this client's immunization record may be shared with Massachusetts health care providers, schools, and other agencies as described in M.G.L. c. 111, s.24M "No" status limits access of the client's immunization information to only the health care provider site that entered the information into the system. "NO" requires signing an objection form and delay in scheduling you for the shot.

Site for shot (left or right arm):

Street Address:

Address Line 2:

City:

State:

Zip:

I acknowledge the above answers provided were correct to the best of my knowledge and that I have reviewed the Vaccine Information Sheet for the vaccine provided: (sign) _____ date: _____

PLEASE PRINT THIS FORM AND BRING IT WITH YOU TO THE VACCINATION SITE. If you are unable to print, we will have blank forms that you can fill out at the site. Preprinting will save time and get you through faster. Thank you.