



Recipient Registration Form



Fields with an * are required

*First Name

*Last Name

*Street Address

*Town/City/State/Zip or Postal Code

Phone Number

*Gender

- Female
- Male
- Decline to Specify
- Other

*Date of Birth

*Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown/Not Reported

*Race (Please check all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Unknown/Not Reported



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Emergency Contact Name

Emergency Contact Number

***Name of School**

I have read, or had explained to me, the information sheet about the Pfizer vaccine (COVID shot). I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine as described. I request the Pfizer vaccine be given to me (or the person named above for whom I am authorized to make this request).

***Signature of Recipient (or Parent/Guardian)**

Date

***Signature of person completing form for recipient**

Date