



Cape May County COVID-19 Patient Vaccination Form AGE 18 AND OVER

FOR OFFICIAL USE ONLY	
Moderna	J&J
<input type="checkbox"/> 1st	<input type="checkbox"/> 1st
<input type="checkbox"/> 2nd	<input type="checkbox"/> Booster
<input type="checkbox"/> 3 rd OR Booster (Circle which one)	

Name: _____ DOB: ____/____/____ Age: _____ Sex: Male Female

Home Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ Email Address: _____

Race: (Circle one)

American Indian or Alaska Native/ Asian/ Black or African American/ Native Hawaiian or Other Pacific Islander/ White/ Other/ Prefer not to Specify

Ethnicity: (Circle one)

Hispanic/Latino/ Non-Hispanic/ Prefer not to Specify

Historical Shot Information:

Verified Card

1st Dose-Date _____ Brand: _____

2nd Dose-Date _____ Brand: _____

I am electing to receive a vaccination against Coronavirus. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the Fact Sheet. I understand the risks and benefits of this vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I hereby waive any claim for damages that I or anyone claiming on my behalf may have against the County, Health Department, clinic, employees and/or agents on account of any injury or misfortune I may suffer as a result of this vaccination. I further understand information will be entered into the New Jersey Immunization Information System.

Today's Date ____/____/____ Patient Signature _____

Today's Date ____/____/____ Vaccine Administrator Signature _____

Medical staff use only: Site: <input type="checkbox"/> RD <input type="checkbox"/> LD	PFIZER MODERNA J&J
	AFFIX STICKER HERE

