Government of the Republic of Trinidad and Tobago
Ministry of Health

COVID-19 Vaccination Pre-Registration Form

1. BIODATA *(To be completed by Applicant*

Vaccination Site

Last Name **First Name** **Other**

Identification Type

ID **DP**

BP **PP**

Date of Birth (dd/mm/yyyy)

Gender

Male **Female**

Identification No. **Age** **Nationality**

Address **Contact No. (xxx-xxxx)** **Name of Next of Kin**

Place of Work **Next of Kin Contact No.**

Email

STOP HERE! DO NOT COMPLETE THE REST OF THE FORM

FOR OFFICIAL USE ONLY *(To be completed by Screening and Administering Nurse)*

2. PRE-VACCINATION SCREENING

	Yes	No	Details
1. Are you well today?			
2. Do you have flu-like symptoms? e.g. Runny nose, fever			
3. Do you have any medical conditions that we should be aware of? e.g. Diabetes Mellitus, Hypertension (If yes, state in details)			
4. Have you received any other vaccination in the last month? (If yes, state in details)			

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	Yes	No	Details
5. Do you have allergies? e.g. Seafood, eggs, antibiotics (If yes, state in details)			
6. Have you ever had a confirmed allergic reaction to the first dose of the COVID-19 vaccine?			
7. Are you currently pregnant?			
8. Are you currently breastfeeding?			
9. Have you tested positive for coronavirus infection within the last 3 months?			
10. Do you have a bleeding disorder, or are you currently taking or have recently stopped taking Warfarin?			
11. Do you have any questions about your vaccination today?			
12. Do you consent to receiving the COVID-19 vaccine?			
13. Is this your second dose of COVID-19 Vaccine?			
14. Did you contract the COVID-19 Virus after your first shot? If yes what date?			

3. VACCINATION INFORMATION

Date of Vaccination (dd/mm/yyyy)

Name of Vaccine

Expiry Date

Batch No.

Blood Pressure

Blood Glucose Level

Observation

Time In:

Time Out:

Adverse Reaction

Yes ☐ **No** ☐

Description of Event

Immunization Card Issued

Next Appointment Date

Name of Vaccinator (CAPS)

Signature of Vaccinator