Ministry of Health National Vaccine Registration Form

Please complete the vaccine registration form below. Thank you!

GOVERNMENT OF THE VIRGIN ISLANDS
Ministry of Health and Social Development

Section A: Patient Demographics

First Name:	Last Name:
Date of Birth (dd/mm/yyyy):	Sex: ☐ Male ☐ Female
Age (years):	Telephone (mobile) number:
Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown / Not Reported	
Race: ☐ American Indian/Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown / Not Reported ☐ Asian ☐ Black or African American ☐ More Than One Race	
Residency Status: ☐ BVIslander/ Belonger ☐ Work Permit Holder/Exempt ☐ Resident ☐ Visitor	
Email:	
Address (Street):	Address (Island):

2. Please select and provide one valid source of identification

	Identification	**Number/Identifier**
☐	Social Security Number	
☐	National Health Insurance	
☐	Driver's License	
☐	Passport	
☐	Other **valid** source	

3. Please select your Employment Status

☐ Employed (Full time)	☐ Employed (Part time)
☐ Student	☐ Unemployed
☐ Retired	
☐ Other, → **please specify:**	

4. Please select your worker Status.

☐	Frontline or Essential Worker
☐	Other

4a. If you are a front-line worker/essential worker, please select the organization currently employed with:

☐ BVI Department of Immigration
☐ BVI Electricity of Corporation
☐ Department of Agriculture
☐ Department of Education
☐ Department of Public Works
☐ Department of Waste Management
☐ Funeral Homes and Funeral Services
☐ Health-care Professional (Front-line responders, Public/Env Health, Ambulatory Services, Technicians)
☐ Her Majesty's Prison
☐ Her Majesty's Customs
☐ Ministry of Education & Culture
☐ Non-government organisation (e.g. BVI Red Cross, Family Support Network)
☐ Royal Virgin Island Police Force/ Law Enforcement Social Development
☐ Virgin Islands Fire and Rescue
☐ Other Organization

4b. If *other*, please specify:

5. Please state your Job Title/Occupation:

Section B: Health Information

6. Please state your:	Height (feet & inches):	Weight(lbs):
7. Are you pregnant or breastfeeding?		☐ Yes ☐ No
8. Do you have any Chronic Health Conditions or a serious health condition?		☐ Yes ☐ No
→ **If yes, please list all health conditions:**		
9. Do you have a weakened immune system (i.e. from cancer, HIV, Lupus) or on immunosuppressive drugs?		☐ Yes ☐ No
10. Do you have a bleeding disorder or are currently taking a blood thinner?		☐ Yes ☐ No
11. Do you have any allergies?		☐ Yes ☐ No
→ **If yes, please list all allergies (including food allergies)**		
12. Have you ever had chicken pox?		☐ Yes ☐ No ☐ Unknown

13. Have you ever been diagnosed with or tested positive for Covid-19?	☐ Yes ☐ No
14. Please provide date of diagnosis. (dd/mm/yy)	
15. Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	☐ Yes ☐ No
16. Have you had any type of vaccine in the last 2 weeks?	☐ Yes ☐ No
17. Have you ever had a severe allergic reaction to a vaccine or any injection in the past?	☐ Yes ☐ No

General Comments	
Is there anything of concern you think might cause you to have an adverse(negative) reaction to the vaccine?	
Any other comments or queries?	

Signature	