



Staff Initials: _____ Time: _____ Date: _____

PERSONAL INFORMATION FORM COVID-19 VACCINE INTAKE

Lincoln Public Schools

Legal Last Name _____ Legal First Name _____ Date of Birth _____ Age: _____

Sex assigned at birth? Male Female Intersex

Mailing/Billing Address: Street Number _____ Street Name _____ Apt. Number _____ City _____ State _____ Zip Code _____

Address where you live (if different from above): _____

Best phone number to contact: () - H/C/W 2nd phone number to contact: () - H/C/W

What is your e-mail address: _____ Is it OK to receive e-mail from us at this address? Yes No

Emergency Contact (name & #)	Relationship to Client

E-mail address: _____

What is your racial identity? one or more boxes and print origins

American Indian or Alaska Native Black or African American White Asian Pacific Islander Unknown/Unreported

Another race – Print race or origin. _____ Optional: What is your place of birth? _____

Are you of Hispanic, Latinx, or Spanish origin? No, not of Hispanic, Latinx or Spanish origin Yes, Mexico, Mexican Am., Chicano Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latinx, or Spanish origin – Print, for example, Salvadorian, Dominican Republic, Colombian, Guatemalan, Spaniard, etc. _____ Primary Language: _____

Primary Payer/Insurance Information (insurance is not charged, **NOT REQUIRED**)

Do you have any of the following? (Check all that apply and circle primary insurance): Private Insurance – Specify _____
 Medicaid/MassHealth Medicare Health Safety Net Veteran's Insurance

Consent for COVID-19 Vaccine

I acknowledge that I have been provided and have read the Emergency Use Authorization Fact Sheet for Recipients and Caregivers for the Moderna (2 doses) Janssen (1 dose) Pfizer (2 doses) COVID-19 Vaccine and the Massachusetts Immunization Information System Fact Sheet. I have completed the COVID-19 Vaccine pre-vaccination screening form to the best of my knowledge. I have had the opportunity to speak with a health care provider to answer any questions I may have about the COVID-19 Vaccine and I understand the benefits and risks associated with the COVID-19 Vaccine.

I understand that I can review a Notice of Privacy Practices at the time of vaccination.

I understand and agree that Program RISE at JRI Health's administration of the COVID-19 Vaccine to me does not make Justice Resource Institute Inc. (JRI) (or any individual associated with JRI) my health care provider and does not create a health plan or constitute any type of health insurance coverage or policy. Apart from administering the COVID-19 Vaccine to me, I understand and agree that JRI has not provided and is not responsible for providing any health care services to me.

I hereby release and hold the Justice Resource Institute, Inc. and its Board of Trustees, officers, employees, and agents harmless from any and all liability and damages arising from or in any way related to the COVID-19 Vaccine and JRI's administration of the COVID-19 Vaccine to me.

I hereby fully consent to the administration by JRI of the vaccine checked above and allow JRI to follow up with me as needed.

<input type="checkbox"/> Participant <input type="checkbox"/> Guardian Print Name: _____	Date: _____	<input type="checkbox"/> Participant <input type="checkbox"/> Guardian Signature: _____
Staff – Print Name: _____	Date: _____	Staff Signature: _____