NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Recipient Registration & Health Questionnaire

CONTACT AND DEMOGRAPHIC DETAILS

Please fill out ALL the information below

First Name: _____ **Last Name:** _____
Birthdate: _____
Email: _____
☐ I do not have an email/ I do not wish to disclose this information

What is the name of the organization you work or reside in? _____

Please select your Industry (Please Select Only One):

Frontline Essential Workers
- ☐ Commercial Facilities for Essential Goods
- ☐ Critical Manufacturing
- ☐ Education
- ☐ Food and Agriculture
- ☐ Governmental and Community Services
- ☐ Health Care
- ☐ Public Health
- ☐ Public Safety
- ☐ Transportation

Other Essential Workers (Non-Frontline)
- ☐ Commercial Facilities (e.g. retail workers, hotel workers)
- ☐ Defense Industrial Base
- ☐ Energy
- ☐ Finance
- ☐ Hygiene Products and Services
- ☐ Industries involving Chemicals or Hazardous Materials
- ☐ IT & Communication
- ☐ Public Works and Infrastructure Support Services
- ☐ Residential Facilities, Housing, and Real Estate
- ☐ Water and Wastewater

Other Industries
- ☐ Other / Not Applicable

Street: _____
City: _____ **County:** _____
State: _____ **Zip Code:** _____
Home Phone: _____ **Mobile Phone:** _____

Communication Preference:
- ☐ Email
- ☐ SMS
- ☐ Both
- ☐ None

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Gender:
- ☐ Male
- ☐ Female
- ☐ Unknown

Are you a member of a state or federal recognized tribal nation?
- ☐ Yes
- ☐ No

If yes, what is the name of the community?_____

Recipient Registration & Health Questionnaire

Do you identify as any of the following?

- ☐ Frontline Essential Worker (In Person at Work) *
- ☐ Other Essential Worker (non-frontline)
- ☐ Patient-facing Healthcare/ Long Term Care Facility Worker **
- ☐ Resident of Congregate/Group Setting
- ☐ Resident of Long-Term Care Facility
- ☐ Student
- ☐ None of the above

(*) The CDC defines frontline essential workers as first responders (e.g., firefighters and police officers), corrections officers, food and agricultural workers, U.S. Postal Service workers, manufacturing workers, grocery store workers, public transit workers, and those who work in the education sector (teachers and support staff members) as well as child care workers.
(**) Patient facing direct health care workers includes any paid or unpaid health care workers with direct patient contact.

MEDICAL DETAILS

Review the below list of conditions known to increase risk of severe illness to COVID-19:

- Asthma
- Cancer
- Cerebrovascular Disease
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease
- Cystic Fibrosis
- Hypertension or High Blood Pressure
- Type 1 Diabetes Mellitus
- Type 2 Diabetes
- Immunocompromised from solid organ transplant
- Immunocompromised state (weakened immune system)
- Liver Disease
- Neurologic conditions, such as Dementia
- Obesity
- Overweight (BMI > 25 kg/m2, but < 30 kg/m2)
- Pregnancy
- Pulmonary Fibrosis (having damaged or scarred lung tissues)
- Sickle Cell Disease
- Smoker
- Thalassemia (a type of blood disorder)

How many conditions known to increase risk of severe illness from COVID-19 do you have?

- ☐ None
- ☐ 1
- ☐ 2 or more

CONSENT

☐ I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available to me.

_____

Signature of Recipient