

COVID-19 Immunization Screening and Consent Form 05 5891

Recipient Name (please print)	Preferred Name
DOB	0046(at)DC Q q 107.GSn.004 Tcd6 -0 0 9r 0.001 Tc -0.001 Tw 9.96 -0 0 9.96 112.8 653.52 Tm [(C)3.9 (u

Parent/Guardian/ Surrogate (if applicable, please pr Phone

Preferred Language

6.	Do you have cancer, leukemia, HIV/AIDS, or any other condition that weakens the immune system?	Yes	No	Unknown
7.	Do you take any medications that affect your immune system, such as cortisone, prednisone, or other			