*COVID-19 Vaccine Survey Form (新冠疫苗注册调查表)*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **病人 (Patient):** |  |  |  |  |  |  | **性别 (Sex):** |  |
|  | **姓 (LastName)** |  | **名 (First Name)** |  | **Middle Initial** |  | **男 (M)** | **女 (F)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **出生日期**  **(Date of Birth):** |  | **年龄**  **(Age):** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **家庭地址 (Address):** | |  | | |
|  | | 街道 (Street) 城市 (City) 州 (State) 邮政编码 (Zip Code) | | |
| **职业 (Occupation):** |  | | **雇主 (Employer):** |  |
|  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **住宅电话**  **(Home Phone):** |  | **手机**  **(Cell):** |  | **电子邮件**  **(Email):** |  |

**有否医疗保险 (Do you Have Medical Insurance?)**: Please check \*

没有 (No) 有 (Yes) ­­­­

|  |  |
| --- | --- |
| 保险公司名称 (Insurance Company): |  |
| 医疗保险号码 (ID # and group #): |  |

|  |  |
| --- | --- |
| **有否家庭医生**  没有 (No) 有 （Yes) ­­­­  **家庭医生姓名和电话** ( Primary Care Physician): | / |

**紧急联系人信息 (Emergency Contact Information)**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **姓名(Name):** |  | **与患者关系 (Relationship):** |  | **电话/电子邮件**  **(Phone/email):** |  |

Plasase answer all question by best of your knowledge (请回答下列问题)

这是您第一次或第二次接受新冠疫苗注射？ (Is this your first or second COVID-19 vaccination?)

第一次  ­第二次

您有下列慢性病史吗？ (Do you have any of the following chronic health conditions?

|  |  |  |
| --- | --- | --- |
| **Chronic Health Conditions** 慢性**疾病史** | **Yes 有** | **No 没有** |
| Cancer 癌症 |  |  |
| Chronic Kidney Disease 慢性肾病 |  |  |
| COPD (Chronic Obstructive pulmonary disease) 慢性阻塞性肺病 |  |  |
| Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies 心脏疾病（例如心衰、冠心病或心肌病） |  |  |
| Immunocompromised state (weakened immune system) from solid organ transplant 实体器官移植后免疫功能低下状态（即免疫系统减弱） |  |  |
| Obesity (body mass index [BMI] of 30 kg/m2 or higher but < 40 kg/m2)  肥胖（体重指数BMI在 30 - 40 kg/m2之间） |  |  |
| Severe Obesity (BMT >= 40 kg/m2) 重度肥胖 （体重指数BMI > 40 kg/m2） |  |  |
| Pregnancy 您是否怀孕？ |  |  |
| Could you become pregnant in the next several weeks?  您在接下来几周内是否有可能怀孕? |  |  |
| Are you breastfeeding (nursing)? 您目前是否正在哺乳？ |  |  |
| Sickle Cell disease 镰状细胞性贫血 |  |  |
| Smoking 抽烟 |  |  |
| Type 2 diabetes mellitus II-型糖尿病 |  |  |
| Have you previously received a COVID-19 vaccine? 您是否已注射过新冠疫苗？ |  |  |
| Have you had a severe allergic reaction (e.g., anaphylaxis) after receiving COVID-19 vaccine? 您在接种新冠疫苗后有无出现严重的过敏反应？ |  |  |
| Do you have a history of anaphylaxis or anaphylactic reaction after vaccination or other injectable medications; to food (e.g., nuts/tree nuts, shellfish, eggs); insect bites (e.g. bee stings); venom; latex; or any other item not listed? 您在接种疫苗、注射药物、食用各种食品（例如坚果/树坚果，贝类，鸡蛋）、昆虫叮咬（例如蜜蜂）、 蛇毒或蜘蛛毒液、乳胶、 或其它未列出的项目后，是否出现过过敏反应？ |  |  |
| Do you have a bleeding disorder or are you taking a blood thinner?  您是否患有出血性疾病或正在服用抗凝剂？ |  |  |
| Are you immunocompromised (have a weakened immune system such as cancer, leukemia, HIV/AIDS, or any other immune system problem) or are you taking medication that affects your immune system?  您的免疫功能是否低下（即患有减弱免疫系统功能的疾病，如癌症、白血病、艾滋病或其它免疫系统疾病）？ 您是否正在服用影响免疫系统功能的药物？ |  |  |
| Do you have a fever? 您现在有发热吗？ |  |  |
| Are you feeling sick? 您现在是否感觉不适？ |  |  |

我, ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 保证上述信息是真实准确的。如果我的健康状况发生变化和/或上述任何信息需要更改时，我会及时通知诊所。

I ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ certify that the above information is true and correct to the best of my knowledge. I will notify you of any changes in my health status and/or information listed above.)

申请人签字 （(Authorized Signature of Subscriber) 日期 （Date）

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备注：

**亚美义诊和中文学校疫苗工作小组会尽最大努力设法帮助像您这样在注册方面有困难的人群预约新冠疫苗，但我们需说明：**

1. **亚美义诊本身不提供疫苗注射，我们只是帮助您预约。我们不能100%地确保能约上新冠疫苗，但我们会尽最大努力帮助您。**
2. **我们不对所预约人在接种前和接种后的身体状况负任何责任。有关您是否适合接受疫苗注射，请咨询您的医生。**
3. **如果我们为您预约到疫苗注射，请您尽一切努力去接种点按时接种。在特殊情况下，如您需要取消预约，请在注射**24**小时之前通知我们，以便我们帮助您及时取消预约。**

4. 我们会尽最大努力去约离您家近的接种点，但受诸多条件限制，如未能如愿，约到了稍远的接种点，也请您谅解。