BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

COVID-19 Vaccination Clinic Demographic Form

Last Name	First Name	Identification (eg., health card number)
Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Prefer not to answer		Primary Care Clinician.(Family Physician or Nurse Practitioner)
Home Phone / Mobile Phone / Email Address		
Street Address	City	Province / Postal Code
Date of Birth (month, day, year) / Age	Is this your **first or second** dose of the vaccine? ☐ First ☐ Second If second, please indicate the date of the first dose: _ _ _ _ _ / _ _ _ _ _ / _ _ _ _ _ (month, day, year)	