HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION

COVID-19 Vaccination Appointment Request Form

1. VACCINATION CLINIC LOCATION (Choose one)

☐ Kauai Veterans Memorial Hospital ☐ Samuel Mahelona Memorial Hospital

2. CONTACT INFORMATION

NAME: _____
First Full Middle Last

Physical Address: _____
Street City State Zip code

Mailing Address: _____
Street/PO Box City State Zip code

Phone: (_____)_____ (_____)_____ Email: _____
Home Mobile

Emergency Contact: _____
Name Phone # Relationship

3. DEMOGRAPHICS

Date of Birth (mm/dd/yyyy): _____ GENDER: ☐ M ☐ F

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

Ethnicity:
☐ Hispanic or Latino
☐ Non-Hispanic
☐ Non-Latino

4. INSURANCE INFORMATION

Primary Care Physician: _____

Insurance Provider: _____ Subscriber ID/Policy #: _____

Insurance Provider: _____ Subscriber ID/Policy #: _____

Insurance Provider: _____ Subscriber ID/Policy #: _____