HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION
E PONO MAU LOA
Always Excellent

Please fill out ALL of the information below to request a time to schedule your COVID-19 vaccination. One form per person. Optional: Caregivers seeking a vaccination, please complete a separate form. Email this form to: KauaiCovid19@hhsc.org
Please allow 2 business days for processing.

1. CONTACT INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____

Date of Birth (mm/dd/yyyy) _____ Gender ☐ Male ☐ Female

Physical address:

Street/PO Box: _____ City: _____ State: _____ Zipcode: _____

Mailing address:

Street/PO Box: _____ City: _____ State: _____ Zipcode: _____

Phone number: (xxx) yyy-zzzz: (_____) _____ E-mail: _____

Insurance Provider: _____ Policy Number: _____ PCP: _____

2. SELECT A VACCINATION LOCATION:

☐ Kauai Veterans Memorial Hospital ☐ Samuel Maheloha Memorial Hospital

3. SELECT DATE AND TIME FOR OPTION 1 AND OPTION 2

OPTION 1

Select a Date (Check ONE):

☐ Fri., Jan. 15 ☐ Tues., Jan. 19 ☐ Fri., Jan. 22

Select a Time (Check ONE):

☐ 8:00am ☐ 9:00am ☐ 10:00am ☐ 11:00am
☐ 8:20am ☐ 9:20am ☐ 10:20am ☐ 11:20am
☐ 8:40am ☐ 9:40am ☐ 10:40am ☐ 11:40am
☐ 12:00pm

OPTION 2

Select a Date (Check ONE):

☐ Fri., Jan. 15 ☐ Tues., Jan. 19 ☐ Fri., Jan. 22

Select a Time (Check ONE):

☐ 8:00am ☐ 9:00am ☐ 10:00am ☐ 11:00am
☐ 8:20am ☐ 9:20am ☐ 10:20am ☐ 11:20am
☐ 8:40am ☐ 9:40am ☐ 10:40am ☐ 11:40am
☐ 12:00pm

4. PLEASE LET US KNOW ANY ADDITIONAL ACCOMMODATIONS YOU MIGHT NEED:

5. EXISTING MEDICAL CONDITIONS (CHECK ANY THAT APPLY)

☐ Cardiovascular Disease
☐ Diabetes
☐ Immunosuppressive Disease
☐ Hypertension
☐ Chronic Kidney Disease
☐ Currently receiving Immunosuppressive Therapy
☐ Chronic Obstructive Pulmonary Disease (COPD) or other Respiratory Disease
☐ List other current medical conditions: _____
_____