GRAPEVINE DRUG COVID VACCINE PRIORITIZATION FORM

Name: **Phone#:**

Are you over 65 years of age? ☐

Are you a healthcare worker? ☐
If yes, where? _____

Are you a First Responder? ☐
If yes, where? _____

Do you have any of the following:

- **Cancer** ☐
- **Chronic Kidney Disease** ☐
- **COPD** ☐
- **Heart Condition** ☐
- **Solid Organ Transplantation** ☐
- **Obesity** ☐
- **Preganacy** ☐
- **Sickle Cell Disease** ☐
- **Type 2 Diabetes** ☐