

```
<!DOCTYPE html>
```

```
<html>
```

```
<head><title>COVID 19 VACCINE REGISTRATION</title></head>
```

```
<img src=https://www.remedygroup.in/images/services/main_1628584264.jpg width="1000px" height="500px">
```

```
<form style="background-color: rgb(198, 120, 167);">
```

```
<h1>REGISTRATION FORM</h1>
```

```
<label for>USER NAME</label for>
```

```
<input type="text" name="username">
```

```
<br></br>
```

```
<label for>NATIONAL SECURITY NUMBER</label for>
```

```
<input type="text" name="national security number">
```

```
<br></br>
```

```
<label for>BIRTH DATE</label for>
```

```
<input type="text" name="birth date">
```

```
<br></br>
```

```
<label for>GENDER</label for>
```

```
<br></br>
```

```
<input type="radio" id="male" name="Male">
```

```
<label for="male">male</label for>
```

```
<br></br>
```

```
<input type="radio" id="Female" name="Female">
```

<label for="Female">Female</label for>

</br>

<label for>EMAIL</label for>

<input type="text" name="Email">

</br>

<label for>PHONE NUMBER</label for>

<input type="text" name="Phone number">

</br>

<label for>ADDRESS</label for>

<input type="text" name="address">

</br>

<label for>CITY</label for>

<input type="text" name="CITY">

</br>

<label for>STATE/PROVINCE</label for>

<input type="text" name="State/province">

<select><option selected disabled>..CURRENT AGE</option><option>15-20</option><option>20-30</option><option>30-40</option><option>40-50</option>

<option>50-60</option><option>60-70</option><option>70-90</option><option>90-100</option></select>

<h3>Symptoms</h3>

<input type="checkbox" id="Dry cough" name="Dry cough" value="Dry cough">

<label for="Dry cough">Dry cough</label>

<input type="checkbox" id="Shortness of breath" name="Shortness of breath" value="Shortness of breath">

<label for="Shortness of breath">Shortness of breath</label>

<input type="checkbox" id="Loss of taste or smell" name="Loss of taste or smell" value="Loss of taste or smell">

<label for="Loss of taste or smell">Loss of taste or smell</label>

<input type="checkbox" id="Fever or chills" name="Fever or chills" value="Fever or chills">

<label for="Fever or chills">Fever or chills</label>

<input type="checkbox" id="Extreme tiredness, called fatigue" name="Extreme tiredness, called fatigue" value="Extreme tiredness, called fatigue">

<label for="Extreme tiredness, called fatigue">"Extreme tiredness, called fatigue"</label>

<form>

<button type="submit">Submit</button>

</form>

</body>

</html>