Page 1 of Covid Application form:

```
<!DOCTYPE html>
<html>

<head>
    <title>Covid Vaccine Form</title>
    <meta name="viewport" content="width=device-width, initial-1.0">
    <link rel="stylesheet" href="style.css">
</head>

<body>
    <div class="container">
        <img src="health.jpg">

        <h1>Covid-19 Vaccination Pre-Registration Form</h1>
        <ul>
            <li><b>1. BIODATA</b> <i>(To be completed by Applicant in all capi
tal letters)</i></li><br>
        </ul>

        <form>
            <label>Vaccination Site</label><br>
            <input type="text" name="Vaccination Site" id="Vaccination" requir
ed><br>
            <label>Last Name</label> <label>First Name</label> <label id="oth"
>Other</label><br>
            <input type="text" name="last name" id="last name" required>
            <input type="text" name="first name" id="first name" required>
            <input type="text" name="other" id="other" required> <br>
            <label>Identification</label> <label id="d"> Date of Birth (dd/mm/
yyyy)</label> <label id="g">Gender</label><br>
            <input type="checkbox" name=" identification" id="identification">
 ID
            <input type="checkbox" name=" identification" id="dp"> DP
            <input type="date" name="date" id="date" required>
            <input type="checkbox" name=" gen" id="gen"> Male
            <input type="checkbox" name=" identification" id="identification">
 Female<br>
            <input type="checkbox" name=" identification" id="check"> BP
            <input type="checkbox" name=" identification" id=""> PP <br>
            <label>Identification No.</label> <label id="age">Age</label> <lab
el id="nat">Nationality</label><br>
            <input type="text" name="id no" required>
            <input type="text" name="age " required>
            <input type="text" name="nationality" id="nationality" required><b
r>
            <label>Address</label> <label id="contact">Contact No. (xxx-
xxxx)</label> <label id="kin">Name of Next of Kin</label><br>
```

```
            <textarea id="atarea" required></textarea>
            <input type="text" name="contact" id="cont" required>
            <input type="text" name="kin" id="nkin" required>
            <label>Email</label> <label id="work">Place of Work</label> <label
 id="ckin">Next of Kin Contact No.</label><br>
            <input type="email" id="email" name="email" required>
            <input type="text" name="work" id="wo" required>
            <input type="text" name="kin" id="nkinc" required>


            <ul>
                <li><b>STOP HERE! DO NOT COMPLETE THE REST OF THE FORM</b></li
><br>
            </ul>
            <hr>
            <ul>
                <li><b>FOR OFFICIAL USE ONLY</b></li><br>
            </ul>
            <ul>
                <li><b>2. PRE-VACCINATION SCREENING</b></li><br>
            </ul>

            <table>
                <tr>
                    <th></th>
                    <th>Yes</th>
                    <th>No</th>
                    <th id="third">Details</th>
                </tr>
                <tr>
                    <td>1. Are you well today?</td>
                    <td id="one"><input type="checkbox" id="yes" name="yes"></
td>
                    <td id="two"><input type="checkbox" id="no" name="no"></td
>
                    <td><input type="text" id="tabletext"></td>
                </tr>
                <tr>
                    <td>2. Do you have any flu-
like symptoms? e.g. Runny nose, fever</td>
                    <td id="one"><input type="checkbox" id="yes" name="yes"></
td>
                    <td id="two"><input type="checkbox" id="no" name="no"></td
>
                    <td><input type="text" id="tabletext"></td>
                </tr>
                <tr>
```

```
                    <td>3. Do you have any medical conditions that we should b
e aware of? e.g. Diabetes Mellitus, Hypertension (If yes, state in details)</t
d>
                    <td id="one"><input type="checkbox" id="yes" name="yes"></
td>
                    <td id="two"><input type="checkbox" id="no" name="no"></td
>
                    <td><input type="text" id="tabletext"></td>
                </tr>
                <tr>
                    <td>4. Have you received any other vaccination in the last
 month? (If yes, state in details)</td>
                    <td id="one"><input type="checkbox" id="yes" name="yes"></
td>
                    <td id="two"><input type="checkbox" id="no" name="no"></td
>
                    <td><input type="text" id="tabletext"></td>
                </tr>
            </table>
        </form>
        <p id="p3">This Form is part of the Patient’s Medical Records and is t
he Property of the Ministry of Health (MOH),<br> Government of the Republic of
 Trinidad and Tobago (GORTT).</p>
    </div>
    <a href="Page2.html"><button>Next Page</button></a>
</body>

</html>
```

Page 2 of Covid-19 vaccine application form

```
<!DOCTYPE html>
<html>

<head>
    <title>Covid Vaccine Form</title>
    <meta name="viewport" content="width=device-width, initial-1.0">
    <link rel="stylesheet" href="style.css">
</head>

<body>
    <div class="container">
        <h1>Confidential</h1>

        <table>
            <tr>
                <th></th>
                <th>Yes</th>
                <th>No</th>
                <th id="third">Details</th>
            </tr>
            <tr>
                <td>1. Are you well today?</td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>2. Do you have any flu-
like symptoms? e.g. Runny nose, fever</td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>3. Do you have any medical conditions that we should be aw
are of? e.g. Diabetes Mellitus, Hypertension (If yes, state in details)</td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>4. Have you received any other vaccination in the last mon
th? (If yes, state in details)</td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
```

```
            <tr>
                <td>5. Do you have allergies? e.g. Seafood, eggs, antibiotics
(If yes, state in details)</td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>6. Have you ever had a confirmed allergic reaction to the
first dose of the COVID-19 vaccine? </td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>7. Are you currently pregnant?</td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>8. Are you currently breastfeeding?</td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>9. Have you tested positive for coronavirus infection with
in the last 3 months?</td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>10. Do you have a bleeding disorder, or are you currently
taking or have recently stopped taking Warfarin?
                </td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>11. Do you have any questions about your vaccination today
?
                </td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
```

```
            </tr>
            <tr>
                <td>12. Do you consent to receiving the COVID-19 vaccine?
                </td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>13. Is this your second dose of COVID-19 Vaccine?
                </td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
            <tr>
                <td>14. Did you contract the COVID-
19 Virus after your first shot? If yes what date?
                </td>
                <td id="one"><input type="checkbox" id="yes" name="yes"></td>
                <td id="two"><input type="checkbox" id="no" name="no"></td>
                <td><input type="text" id="tabletext"></td>
            </tr>
        </table>

        <ul>
            <li>
                <b>3. VACCINATION INFORMATION</b>
            </li>
        </ul>

        <form>
            <label>Date of vaccination (dd/mm/yyyy)</label><br>
            <input type="date" id="vaxdate" required><br>
            <label>Name of Vaccine</label><label>Expiry Date</label><label id=
"bat">Batch No.</label><br>
            <input type="text" id="nvax" required>
            <input type="date" id="exp" required>
            <input type="text" id="batc" required><br>
            <label>Blood Pressure</label> <label id="bgl">Blood Glucose Level<
/label><br>
            <input type="text" required>
            <input type="text" id="glu" required><br>
            <label>Observation</label><label id="adv">Adverse Reaction</label>
<label id="desc">Desciption Event</label><br>
            <label>Time in:</label><input type="text" id="in" required>
            <input type="checkbox" id="adve"> Yes
            <input type="checkbox"> No
```

```
            <textarea id="tarea"></textarea><br>
            <label>Time out:</label><input type="text" id="in" required><br>
            <label>Immunization Card Issue</label><input type="text" id="ici"
required><br>
            <label>Next Appointment Date</label><input type="date" id="nad" re
quired><br><br>
            <label>Name of Vaccinator (CAPS)</label><input type="text" id="nav
" required><br>
            <label>Signature of Vaccinator</label><input type="text" id="sav"
required><br>
            <button type="submit">Submit</button>
            <p id="p3">This Form is part of the Patient’s Medical Records and
is the Property of the Ministry of Health (MOH),<br> Government of the Republi
c of Trinidad and Tobago (GORTT).</p>
        </form>
    </div>
    <a href="index.html"><button>Previous</button></a>

</body>

</html>
```

Stylesheet for Pages

```css
* {
    margin: 0;
    padding: 0;
}

hr {
    border-top: 3px solid black;
    width: 95%;
    margin: 0 auto;
}

body {
    margin: 0;
    padding: 0;
}

img {
    /* float: left; */
    width: 150px;
    height: 150px;
    /* margin-bottom: 40px; */
}

.container {
    margin: auto;
    width: 80%;
    border-radius: 5px;
    border-color: black;
    border-style: solid;
    margin-bottom: 30px;
}

h1 {
    text-align: center;
}

pre {
    font-family: 'Times New Roman', Times, serif;
}

li {
    margin-left: 20px;
    list-style: none;
}

textarea {
    border-color: rgb(55, 137, 225)
```

```
}

label {
    position: auto;
    margin-left: 30px;
    margin-right: 200px;
}

input[type="text"] {
    margin-left: 30px;
    margin-right: 97px;
    margin-bottom: 20px;
    border-color: rgb(55, 137, 225);
}

input[type="checkbox"] {
    padding: 3px;
    margin-left: 50px;
    transform: scale(1.5);
    margin-bottom: 12px;
    border-color: rgb(55, 137, 225);
}

input[type="email"] {
    border-color: rgb(55, 137, 225);
}

button {
    background-color: #4CAF50;
    margin-left: 45%;
    display: block;
    margin-bottom: 20px;
    border: none;
    color: white;
    padding: 15px 32px;
    text-align: center;
    text-decoration: none;
    font-size: 16px;
    cursor: pointer;
}

input[type="date"] {
    border-color: rgb(55, 137, 225);
}


/* ---------------IDS-----------------*/
```

```css
/* page 1 */

#gen {
    margin-left: 230px;
}

#oth {
    margin-left: 100px;
}

#other {
    margin-left: 100px;
}

#d {
    margin-left: 15px;
}

#g {
    margin-left: -11px;
}

#date {
    margin-left: 155px;
}

#age {
    margin-left: -12px;
}

#nat {
    margin-left: 140px;
}

#nationality {
    margin-left: 100px;
}

#contact {
    margin-left: 48px;
}

#kin {
    margin-left: 15px;
}

#nkin {
    margin-left: 100px;
```

```
}

#address {
    margin-left: 30px;
    height: 50px;
}

#work {
    margin-left: 63px;
}

#ckin {
    margin-left: 78px;
}

#nkinc {
    margin-left: 100px;
}

#email {
    margin-left: 30px;
    width: 220px;
}

#wo {
    margin-left: 78px;
}

#yes {
    margin: auto;
    text-align: center;
    transform: scale(1);
}

#no {
    margin: auto;
    text-align: center;
    transform: scale(1);
    margin-left: 4px;
}

#third {
    width: 140px
}

#p3 {
    text-align: center;
    margin-top: 20px;
```

```
    font-size: 16px;
    font-weight: bold;
}

#tabletext {
    width: 93%;
    margin-top: 20px;
    margin-left: 3px;
}

#atarea {
    resize: none;
    height: 50px;
    margin-left: 30px;
}

#cont {
    margin-left: 135px;
}


/* page 1 end */


/* page 2 */

#vaxdate {
    margin-left: 30px;
    margin-bottom: 20px;
}

#bat {
    margin-left: 80px;
}

#exp {
    margin-left: 65px;
}

#batc {
    margin-left: 210px;
}

#desc {
    margin-left: 45px;
}

#bgl {
    margin-left: 39px;
```

```
}

#glu {
    margin-left: 65px;
}

#adv {
    margin-left: 60px;
}

#in {
    margin-left: -190px;
}

#adve {
    margin-left: 10px;
}

#tarea {
    resize: none;
    height: 50px;
    margin-left: 215px;
}

#ici {
    margin-left: -150px;
}

#nad {
    margin-left: -140px;
}

#nav {
    margin-left: -170px;
}

#sav {
    margin-left: -140px;
}


/* page 2 */


/* ---------- Table ---------- */

table {
    margin: auto;
    margin-bottom: 20px;
```

```css
}

th {
    background-color: grey
}

#one {
    text-align: center;
    vertical-align: middle;
}


/* td {
    text-align: center;
} */

table,
th,
td {
    border: 1px black solid;
    border-collapse: collapse;
}
```

Screenshots of page 1

Ministry of Health

Covid-19 Vaccination Pre-Registration Form

1. BIODATA *(To be completed by Applicant in all capital letters)*

Vaccination Site

Last Name | First Name | Other

Identification: ☐ ID ☐ DP ☐ BP ☐ PP

Date of Birth (dd/mm/yyyy) dd / mm / yyyy

Gender: ☐ Male ☐ Female

Identification No. | Age | Nationality

Address | Contact No. (xxx-xxxx) | Name of Next of Kin

Email | Place of Work | Next of Kin Contact No.

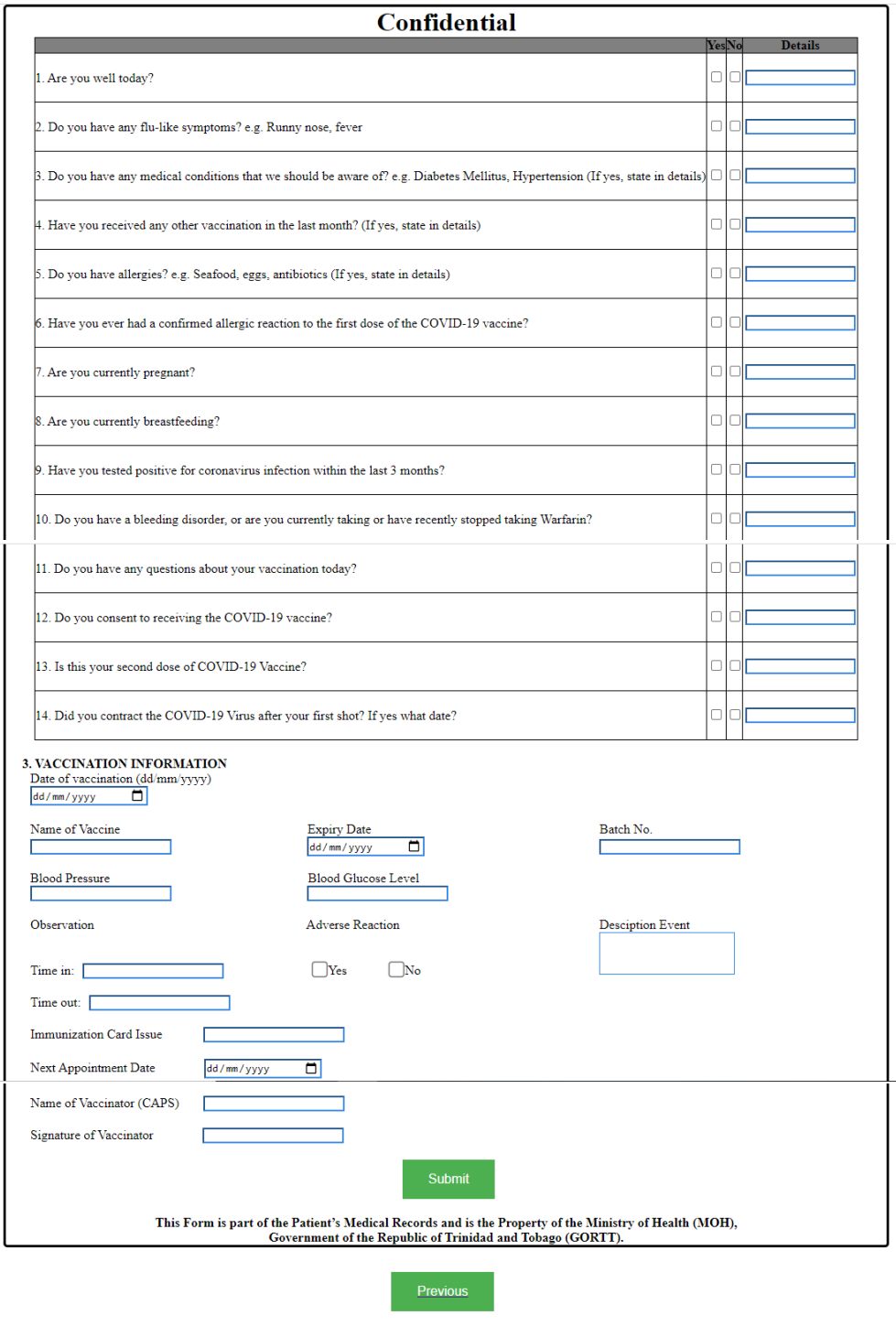
STOP HERE! DO NOT COMPLETE THE REST OF THE FORM

FOR OFFICIAL USE ONLY

2. PRE-VACCINATION SCREENING

	Yes	No	Details
1. Are you well today?	☐	☐	
2. Do you have any flu-like symptoms? e.g. Runny nose, fever	☐	☐	
3. Do you have any medical conditions that we should be aware of? e.g. Diabetes Mellitus, Hypertension (If yes, state in details)	☐	☐	
4. Have you received any other vaccination in the last month? (If yes, state in details)	☐	☐	

Screenshots of Page 2



Confidential

	Yes	No	Details
1. Are you well today?	☐	☐	
2. Do you have any flu-like symptoms? e.g. Runny nose, fever	☐	☐	
3. Do you have any medical conditions that we should be aware of? e.g. Diabetes Mellitus, Hypertension (If yes, state in details)	☐	☐	
4. Have you received any other vaccination in the last month? (If yes, state in details)	☐	☐	
5. Do you have allergies? e.g. Seafood, eggs, antibiotics (If yes, state in details)	☐	☐	
6. Have you ever had a confirmed allergic reaction to the first dose of the COVID-19 vaccine?	☐	☐	
7. Are you currently pregnant?	☐	☐	
8. Are you currently breastfeeding?	☐	☐	
9. Have you tested positive for coronavirus infection within the last 3 months?	☐	☐	
10. Do you have a bleeding disorder, or are you currently taking or have recently stopped taking Warfarin?	☐	☐	
11. Do you have any questions about your vaccination today?	☐	☐	
12. Do you consent to receiving the COVID-19 vaccine?	☐	☐	
13. Is this your second dose of COVID-19 Vaccine?	☐	☐	
14. Did you contract the COVID-19 Virus after your first shot? If yes what date?	☐	☐	

3. VACCINATION INFORMATION

Date of vaccination (dd/mm/yyyy) dd/mm/yyyy

Name of Vaccine

Expiry Date dd/mm/yyyy

Batch No.

Blood Pressure

Blood Glucose Level

Observation

Adverse Reaction

Desciption Event

Time in:

☐Yes ☐No

Time out:

Immunization Card Issue

Next Appointment Date dd/mm/yyyy

Name of Vaccinator (CAPS)

Signature of Vaccinator

Submit

This Form is part of the Patient's Medical Records and is the Property of the Ministry of Health (MOH), Government of the Republic of Trinidad and Tobago (GORTT).

Previous