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 capital letters)</i></li><br>

        </ul>

        <form>

            <label>Vaccination Site</label><br>

            <input type="text" name="Vaccination Site" id="Vaccination" required><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> <label 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><br>

            <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 be aware 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 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 the 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 aware 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 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>

            <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 within 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" required><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 Republic of Trinidad and Tobago (GORTT).</p>

        </form>

    </div>

    <a href="index.html"><button>Previous</button></a>

</body>

</html>

Stylesheet for Pages

\* {

    margin: 0;

    padding: 0;

}

hr {

    border-top: 3px solid black;

    width: 95%;

    margin: 0 auto;

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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-----------------\*/

/\* 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 {

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    text-align: center;

    transform: scale(1);

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}

#p3 {

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    font-size: 16px;

    font-weight: bold;

}

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    margin-left: 3px;

}

#atarea {

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    height: 50px;

    margin-left: 30px;

}

#cont {

    margin-left: 135px;

}

/\* page 1 end \*/

/\* page 2 \*/

#vaxdate {

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    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;

}

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

Graphical user interface, application

Description automatically generated

Screenshots of Page 2

Graphical user interface, text, application, email

Description automatically generatedGraphical user interface, application

Description automatically generatedGraphical user interface, application

Description automatically generated