COVID-19 Vaccine Administration Record

Please Print

Section 1: Vaccine Recipient Information

Recipient Name: _____
Last First M.I.

Previous Last Names: _____ Phone Number: _____

Address: _____
Street City State Postal Code

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

MUST BE 12 YRS OR OLDER

If someone else manages healthcare decisions on the patient's behalf, please provide the following:

Parent/Legal Guardian: _____ **Relationship:** _____ **Phone:** _____

Section 2: Screening for Vaccine Eligibility

Has the person listed above previously received COVID-19 vaccine? ☐ Yes ☐ No

If yes to above, indicate the COVID-19 vaccine previously received:

Vaccine Brand Administered (Pfizer, Moderna, Astra Zeneca, Johnson and Johnson): _____

Date first dose administered: Month _____ Day _____ Year _____

Date second does administered: Month _____ Day _____ Year _____

☐ COVID-19 Vaccine EUA FACT SHEET for Recipients provided

Section 3: Consent

I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request.

Signature: _____ Date: _____

MUST BE 18 YRS OLD

Healthcare Provider Use Only

Date Vaccine Administered: _____ Injection Site (Deltoid): ☐ Left ☐ Right

Manufacturer: Pfizer Lot Number: _____ Exp: _____

Signature: _____ ☐ IRIS

Healthcare Provider Use Only

Date Vaccine Administered: _____ Injection Site (Deltoid): ☐ Left ☐ Right

Manufacturer: Pfizer Lot Number: _____ Exp: _____

Signature: _____ ☐ IRIS