COVID-19 Vaccine Administration Record

Please Print

Section 1: Vaccine Recipient Information

Recipient Name:_____

Last First M.I.

Address:_____

Street City State Zip Code

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

Phone Number (cell):_____ Landline:_____

Section 2: Screening for Vaccine Eligibility

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

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

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

Date first dose administered: Month_____ Day_____ Year_____

Date second dose administered: Month_____ Day_____ Year_____

Section 3: Insurance-Must provide Copy of Insurance Card

Please provide medical insurance information for the vaccine recipient.

Insurance Name:_____ Member ID:_____

_____ Cardholder Name:_____

Relationship to Vaccine Recipient:_____

Medicare Number:_____

Section 4: 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 the 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:_____

Healthcare Provider Use Only

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

Manufacturer:_____ Lot Number:_____ Exp:_____

Administered by (print):_____ Signature:_____

☐ COVID-19 Vaccine EUA FACT SHEET for Recipient provided ☐ Entered in IRIS

Pre-Vaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Form reviewed by _____ **Date** _____