# COVID-19 Vaccine 3rd Dose 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: 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 3rd 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?<br>_____ Pfizer<br>_____ Moderna<br>_____ Another Product _____ | | | |
| **3.** Have you ever had a servere 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 servere allergic reaction after receiving a COVID-19 vaccine? | | | |
| **4.** Have you received another vaccine in the last 14 days? | | | |
| **5.** Have you had a postivie test for COVID-19 or has a doctor ever told you that you had COVID-19? | | | |

Form Reviewed by_____ Date_____