COVID-19 Vaccine Administration Record

**Please print**

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| **Section 1: Vaccine Recipient Information** | | | | | | | | | | | |
| Recipient name: | | |  | | | | |  | | |  |
|  | | | Last name | | | | | First name | | | M.I. |
| Address: |  | | | | | | |  | |  |  |
|  | Street | | | | | | | City | | State | ZIP |
| Date of birth: | |  | | | Age: |  | | Gender: | Male  Female | | |
| **Race** | | | | | | | | | | | | |
| American Indian or Alaska Native  Asian  Native Hawaiian  Other Pacific Islander | | | | | | | Black or African American  White  Other Race | | | | | |
| **Ethnicity** | | | | | | | | | | | | |
| Not Hispanic or Latino | | | | | | | Hispanic or Latino | | | | | |
| **Primary Language** | | | | | | | | | | | | |
| English | | | | | | | Spanish | | | | | |
| Primary Healthcare Provider: | | | |  | | | | | | | |

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| **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 dose administered: | Month |  | Day |  | | Year |  |

|  |  |  |  |  |  |  |
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| **Section 3: Insurance** | | | | | | |
| Please provide medical insurance information for the vaccine recipient. | | | | | | |
| Insurance name: |  | | | | Member ID: |  |
| Social Security Number: | |  | | Cardholder name: | |  |
| Relationship to Vaccine Recipient: | | |  | | | |

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| **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 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: |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Healthcare Provider Use Only** | | | | | | | | | | |
| Date Vaccine Administered: | | | |  | | Injection Site (Deltoid): | | | Left  Right | |
| Manufacturer: | |  | | | Lot number: | |  | Exp: | |  |
| Administered by print: | | |  | | | | | | | |
| Signature: |  | | | | | | | | | |
| COVID-19 Vaccine EUA FACT SHEET for Recipients provided | | | | | | | | | | |