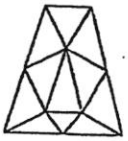

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COVID-19 Vaccine Administration Record

Vaccine Recipient Information

Recipient Name: _____
Last First M.I.

Address: _____
Street City State Postal Code

Date of Birth:_____ Age:_____ Gender: _____Male ___Female

Phone Number: _____Ethnicity: _____

Mother's Maiden Name: _____ Primary Healthcare Provider: _____

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 _____

Insurance

Please provide medical and pharmacy insurance information for the vaccine recipient.

Insurance Name:_____ Member ID: _____

RX BIN:_____RX PCN:_____ Pharmacy Group:_____

Medicare B ID: _____Social Security Number:_____

Cardholder Name: _____Relationship to Vaccine Recipient: _____

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: _____

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

☐ COVID-19 Pre-Vaccination Form (screening form) completed for the vaccine to be provided

Date on VIS/EUA sheet:_____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Name

Age

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.

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	
3. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	
4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	

- If yes, which vaccine product did you receive?

☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product

- Have you received a complete COVID-19 vaccine series *(i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])*?
- Did you bring your vaccination record card or other documentation?

- A component of a COVID-19 vaccine, including either of the following:
  - Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures
  - Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids
- A previous dose of COVID-19 vaccine

5. Check all that apply to you:

☐ Am a female between ages 18 and 49 years old

☐ Am a male between ages 12 and 29 years old

☐ Have a history of myocarditis or pericarditis

☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies

☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum

☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection

☐ Have a bleeding disorder

☐ Take a blood thinner

☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies

☐ Have a history of heparin-induced thrombocytopenia (HIT)

☐ Am currently pregnant or breastfeeding

☐ Have received dermal fillers

☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by

Date

08/20/2021

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists