For Office Use Only:
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AllCare HEALTH CENTER

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/Race: _____

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 or VIS for Recipient provided; Date of VIS: _____

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

Last Updated 12/17/2021

Prevaccination Checklist for COVID-19 Vaccination

Name

For vaccine recipients (both children and adults):

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

	Yes	No	Don't know
1. How old is the person to be vaccinated?			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product was administered?			
☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product			
☐ Moderna ☐ Novavax			
• How many doses of COVID-19 vaccine were administered?			
• Did you bring the vaccination record card or other documentation?	☐	☐	
4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	
6. Has the person to be vaccinated 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.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated 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.)*	☐	☐	☐

8. Check all that apply to the person to be vaccinated:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?
- ☐ Vaccinated with monkeypox vaccine in the last 4 weeks?

Form reviewed by **Date**