

## COVID-19 Vaccine Administration Record

### Section 1: Vaccine Recipient Information

Recipient Name: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Street City State Postal Code

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male Female

Primary Healthcare Provider: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

### 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 \_\_\_\_\_

### 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 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