COVID-19 Vaccine Administration Record

Section 1: Vaccine Recipient Information

Recipient Name: ____

Address:____

Date of Birth:_____________ Age: ________________ Gender: ☐ Male ☐ Female

Primary Healthcare Provider:____

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 ☐ Janssen

Date first dose administered: Month__________Day______Year_______

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:____

Section 4: Consent

I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Fact- sheet 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 the request.

Signature:____Date:_________

Parent/Guardian Signature (if under 18) :________________________________Date:_________

COVID-19 Vaccine Administration Record

Healthcare Provider Use Only

Date Vaccine Administered:_______________

Injection site(deltoid): Left   Right

Manufacturer:_____________________Lot Number:________________Exp:______________________

Administered by Print:_____________________________
Signature:_________________________________