COVID-19 Vaccine Administration Record

Recipient Name: ____
Last First MI

Address: ____
Street City State Postal Code

Date of Birth: ____________________ Age: ___________ Gender: ☐ Male ☐ Female

Primary Healthcare Provider: ____

Cell phone number: ___________________________

Have you had a severe reaction to a vaccine in the past: Yes _____ No ______
Do you carry an epipen due to severe allergic reaction? Yes _____ No ______

Do you have a compromised immune system? Yes _____ No ______
Do you take medication(s) that suppress your immune system? Yes _____ No ______

I have read the information provided in the Emergency Use Authorization (EUA) Factsheet 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.

Signature: ____ Date _________________________

Health Care Provider Only

Has the person listed above previously received COVID-19 vaccine? ☐ Yes ☐No
If yes to above, circle the COVID-19 vaccine previously received:
Vaccine Brand Administered (Pfizer, Moderna, Johnson and Johnson)

Date first dose administered: Month_________ Day _______ Year_______
Date second dose administered: Month_________ Day _______ Year_______

Injection Site (Deltoid): ☐ Left ☐ Right

Signature: ____

☐ COVID-19 Vaccine EUA FACT SHEET for recipients provided

Prevaccination Checklist for COVID-19 Vaccination

For vaccine recipients:

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.

Name ______________________

Age ____________

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ____________			
• How many doses of COVID-19 vaccine have you received? ____________			
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
5. 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.)* • 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	☐	☐	☐
6. 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.)*	☐	☐	☐

7. Check all that apply to you:

- ☐ Am a male between ages 12 and 39 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ 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 history of Guillain-Barré Syndrome (GBS)

Form reviewed by ______________________ **Date** ____________

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