



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 allergy reactin? 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 baccine 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, Astra Zeneca, 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 Vaccines



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.

Patient Name _____

Age _____

Yes No Don't know

1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
<ul style="list-style-type: none"> If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Another product _____ 			
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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
<ul style="list-style-type: none"> A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures 			
<ul style="list-style-type: none"> Polysorbate 			
<ul style="list-style-type: none"> A previous dose of COVID-19 vaccine 			
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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Form reviewed by _____

Date _____