COVID-19 Vaccine Administration Record
Please Print

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: _____

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 _____

Date second does 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) 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