COVID-19 Vaccine Administration Record

Name: _____

Address (street/city/state/zip): _____

Date of Birth: _____ Gender: _____

Cell Phone Number: _____ Email: _____

Vaccine 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: _____

COVID Screening

Have you experienced any of the following symptoms in the past 48 hours circle all that apply:

fever/chills	cough	shortness of breath	fatigue	body aches
headache	loss of taste or smell	sore throat	congestion or runny nose	
nausea	vomiting	diarrhea	NONE	

Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or worried you may be sick with COVID -19? □ YES □ NO

Are you currently waiting on the results of a COVID-19 test? □ YES □ NO

Healthcare Provider Use Only

Date: _____ Injection Site (Deltoid): Left Right

Manufacturer: _____ Lot Number: _____ Exp: _____

Administered by: _____

Time of injection:_____ Time left clinic:_____ Dose 1st 2nd

☐ COVID-19 EAU Fact Sheet for Recipients Provided