COVID-19 VACCINE ADMINISTRATION RECORD (VAR)

Information About Person Receiving Vaccine:				
First Name: (Print)	Middle Name:	Last Name:		Mothers Maiden:
DOB:	Age:	Gender:	Race:	Ethnicity:
Name (Parent or Guardian if applicable)			Phone (Include area code)	Cell Phone (include area code)

Address:	City:	State:	Zip:
County:	Email:		

Prior to administration of the vaccine(s) indicated below, a copy of the Emergency Use Agreement Fact Sheet and a Vaccine Information Statement for each vaccine was provided to me. I was given the opportunity to ask questions regarding the EUA and the vaccine(s) and agree to its administration.

Signature of Parent/Guardian or adult vaccine recipient_____

FOR CLINIC USE ONLY

Prior to administration of the vaccine(s) indicated below, a copy of the Emergency Use Agreement Fact Sheet and a Vaccine Information Statement was provided to the client or representative for whom the vaccine was administered. The client or his/her representative was given the opportunity to ask questions regarding the EUA and the vaccine(s).

Clinic:	Date Vaccinated:	Signature & Title of Vaccine Administrator:

Vaccine:_____

_____ _____

Manufacturer Lot Number

_____ _____

Injection Site Route

VIS Pub Date _____ Dose 1 2 3

Vaccine:_____

_____ _____

Manufacturer Lot Number

_____ _____

Injection Site Route

VIS Pub Date _____ Dose 1 2 3

Vaccine:_____

_____ _____

Manufacturer Lot Number

_____ _____

Injection Site Route

VIS Pub Date _____ Dose 1 2 3

Vaccine:_____

_____ _____

Manufacturer Lot Number

_____ _____

Injection Site Route

VIS Pub Date _____ Dose 1 2 3

Name - _____

DOB - _____

Mother's Maiden Name - _____

Covid 19 Vaccine Insurance Verification and Information

Questions:

1. Do you have history severe allergic reaction (anaphylaxis), including from any prior injectable medications or vaccines? (Anaphylaxis-a severe allergic reaction that leads to wheezing, chest tightness, difficulty breathing, rash, swelling in throat and lowered blood pressure that starts between 5-30 minutes after contact with allergen)
    a. If yes, what are they allergic to: _____ (discuss with COVID MD)
        i. You can proceed to schedule, and we will call patient if a problem
    b. If no, proceed to #2

2. Have you received any other vaccine within the past two weeks?
    a. If yes, what vaccine on what date: _____ (STOP. discuss with COVID MD)
        i. STOP if 14 days or less and may schedule 2weeks after vaccine
    b. If no, proceed to #3

3. Have you recently been exposed to a person with COVID 19 within the last 14 days, or are you currently under quarantine for exposure?
    a. If yes, then must complete quarantine prior to vaccine-can schedule later
    b. If no, proceed to #4

4. Have you received monoclonal antibody or convalescent plasma therapy for Covid 19 in the past 90 days?
    a. If yes, they cannot receive vaccine for 90 days from infusion date-stop here
    b. If no, proceed to #5

5. Have you recently tested positive for Covid 19?
    a. If yes, date of test: _____ (if greater than 14 days then may proceed with vaccine)
    b. If no, then proceed to register patient and verify insurance

Please remind patient to wear clothing that will be easy to access their upper arm.