

Staff Vaccine Administration Record for COVID-19

Staff Name (Print): _____ D.O.B.: ___/___/___ Facility Name: _____							
Education (including benefits & potential side effects) Provided to Staff: COVID-19 Vaccine Education Date ___/___/___ Booster Vaccine Education Date ___/___/___ Addl. Dose Vaccine Education Date ___/___/___ 							
Manufacturer of Vaccine (place X in appropriate box)	Dose of Vaccine (check mL dosage)	Declined (indicate dose in appropriate box)	Vaccine Lot #	Diluent Lot # (if known)	Date Vaccine Given or Declined	Location of Intramuscular Vaccination (place X in appropriate box)	
<input type="checkbox"/> Pfizer *3 weeks recommended between doses	1. <input type="checkbox"/>	1. <input type="checkbox"/>				Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>
	2. <input type="checkbox"/>	2. <input type="checkbox"/>				Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>
<input type="checkbox"/> Moderna *4 weeks recommended between doses	1. <input type="checkbox"/>	1. <input type="checkbox"/>				Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>
	2. <input type="checkbox"/>	2. <input type="checkbox"/>				Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>
<input type="checkbox"/> Janssen/J&J	1. <input type="checkbox"/>	1. <input type="checkbox"/>				Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>
<input type="checkbox"/> Other (Print name) _____	1. <input type="checkbox"/>	1. <input type="checkbox"/>				Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>
	2. <input type="checkbox"/>	2. <input type="checkbox"/>				Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>
Vaccine Type: Booster/Additional Dose (Refer to the CDC's website for recommendations on booster dose versus additional dose)		Declined	Vaccine Lot #	Diluent Lot # (if known)	Date Vaccine Given or Declined	Location of Intramuscular Vaccination (place X in appropriate box)	
Manufacturer: _____		<input type="checkbox"/>				Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>
Manufacturer: _____		<input type="checkbox"/>				Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>
Manufacturer: _____		<input type="checkbox"/>				Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>
1) Contraindication: Immediate allergic reaction of <i>any</i> severity to previous COVID-19 vaccine; reaction to polysorbate, or polyethelene glycol. Refer staff member to allergist/immunologist for COVID-19 vaccine evaluation. Contraindication: _____							
2) Adverse Event (Reaction) to Current Vaccine Administration - Describe any reaction to vaccine: _____							
History of Confirmed COVID-19? YES <input type="checkbox"/> NO <input type="checkbox"/> Date of most recent result: ___/___/___							
Consent for COVID-19 vaccine present in staff member's record? YES <input type="checkbox"/> NO <input type="checkbox"/>							
Check Box if COVID-19 Vaccine, Booster, or Additional Dose Received at Another Location: <input type="checkbox"/>							
Location: _____	Manufacturer: _____	Dose 1 Date: ___/___/___					
Location: _____	Manufacturer: _____	Dose 2 Date: ___/___/___					
Location: _____	Manufacturer: _____	Dose Date: ___/___/___					
Location: _____	Manufacturer: _____	Dose Date: ___/___/___					
Location: _____	Manufacturer: _____	Dose Date: ___/___/___					