STAFF MEMBER VACCINE ADMINISTRATION RECORD FOR COVID-19

Facility Name: _____ **State:** _____

Full Name of Staff Receiving Vaccine: (Print) _____

Vaccine	Manufacturer of Vaccine (place X in appropriate box)	Dose of Vaccine	Declined (indicate dose in appropriate box)	Lot Number	Date Vaccine Given	Location on body site where vaccine was given (place X in appropriate box) *COVID-19 vaccine is an intramuscular (IM) vaccine*	
COVID-19	**Pfizer** ☐ *3 weeks are recommended between doses	1. ☐	1. ☐			**Right Arm** ☐	**Left Arm** ☐
		2. ☐	2. ☐			**Right Arm** ☐	**Left Arm** ☐
	Moderna ☐ *1 month recommended between does	1. ☐	1. ☐			**Right Arm** ☐	**Left Arm** ☐
		2. ☐	2. ☐			**Right Arm** ☐	**Left Arm** ☐
	Other ☐ **(Print name)** _____	1. ☐	1. ☐			**Right Arm** ☐	**Left Arm** ☐
		2. ☐	2. ☐			**Right Arm** ☐	**Left Arm** ☐

1) **Contraindiction:** Immediate allergic reaction of *any* severity to previous COVID-19 vaccine; reaction to polysorbate, or polyethelene glycol. Please describe contrainidaction below. **Refer staff to allergist/immunologist for evaluation related to receiving COVID-19 vaccination.**
Contraindication:_____

2) **Adverse Event (Reaction) to Current Vaccine Administration:**
Describe any reaction to vaccine: _____

Staff Member Declined COVID-19 Vaccine: ☐ (X indicates staff member declined) **Date declined:** _____

COVID-19 Vaccine Received at Another Location? ☐ (X indicates dose of vaccine received at another location)

Name of Location: _____ **Date of Vaccine Received at Other Location:**_____

Dose of Vaccine Received at Other Location: **1.** ☐ **2.** ☐

For Completion by Facility Vaccine Tracking Designee:

History of Lab Positive COVID-19? ☐ (X indicates lab positive COVID-19)

Date of lab result: **Month**___ **Day**__**Year**____ (If more than one previous positive lab result, include most recent date of positive result)

Consent for COVID-19 vaccine present in staff member's record? **YES** ☐ **NO** ☐