Resident Vaccine Administration Record for COVID-19

Resident Name (Print): _____ **Facility Name:** _____

Unit and Room #: _____ **Date of Birth:** _____/_____/_____ **Admission Date:** _____/_____/_____

Education (including benefits & potential side effects) Provided to Resident/Responsible Party:

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)	
☐ **Pfizer** *3 weeks recommended between doses	1. ☐	1. ☐				**Left Arm** ☐	**Right Arm** ☐
	2. ☐	2. ☐				**Left Arm** ☐	**Right Arm** ☐
☐ **Moderna** *4 weeks recommended between doses	1. ☐	1. ☐				**Left Arm** ☐	**Right Arm** ☐
	2. ☐	2. ☐				**Left Arm** ☐	**Right Arm** ☐
☐ **Janssen/J&J**	1. ☐	1. ☐				**Left Arm** ☐	**Right Arm** ☐
☐ **Other (Print name)** _____	1. ☐	1. ☐				**Left Arm** ☐	**Right Arm** ☐
	2. ☐	2. ☐				**Left Arm** ☐	**Right Arm** ☐

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:	☐				**Left Arm** ☐	**Right Arm** ☐
Manufacturer:	☐				**Left Arm** ☐	**Right Arm** ☐
Manufacturer:	☐				**Left Arm** ☐	**Right Arm** ☐

1) **Contraindication:** Immediate allergic reaction of *any* severity to previous COVID-19 vaccine; reaction to polysorbate, or polyethelene glycol. **Refer 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 ☐ NO ☐ **Date of most recent result:** ___/___/___
Consent for COVID-19 vaccine present in resident record? YES ☐ NO ☐

Check Box if COVID-19 Vaccine, Booster, or Additional Dose Received at Another Location: ☐

Location: _____ **Manufacturer:** _____ **Dose 1 Date:** ___/___/___
Location: _____ **Manufacturer:** _____ **Dose 2 Date:** ___/___/___
Location: _____ **Manufacturer:** _____ **Dose Date:** ___/___/___
Location: _____ **Manufacturer:** _____ **Dose Date:** ___/___/___
Location: _____ **Manufacturer:** _____ **Dose Date:** ___/___/___

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