

## Resident Vaccine Administration Record for COVID-19

Resident Name (Print): _____		Facility Name: _____				
Unit and Room #: _____		Date of Birth: ____/____/____				
Admission Date: ____/____/____		COVID-19 Vaccine Education Date ____/____/____				
Education (including benefits & potential side effects) Provided to Resident/Responsible Party:		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		Declined	Vaccine Lot #	Diluent Lot # (if known)	Date Vaccine Given or Declined	Location of Intramuscular Vaccination (place X in appropriate box)
Booster Manufacturer:		<input type="checkbox"/>				Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/>
Additional Dose Manufacturer:		<input type="checkbox"/>				Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/>
1) <b>Contraindication:</b> Immediate allergic reaction of <i>any</i> severity to previous COVID-19 vaccine; reaction to polysorbate, or polyethelene glycol. Refer to allergist/immunologist for COVID-19 vaccine evaluation. Contraindication: _____						
2) <b>Adverse Event (Reaction) to Current Vaccine Administration</b> - Describe any reaction to vaccine: _____						
History of Lab Confirmed COVID-19? YES <input type="checkbox"/> NO <input type="checkbox"/> Date of most recent lab result: ____/____/____						
Consent for COVID-19 vaccine present in resident 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: _____	Booster Date: ____/____/____				
Location: _____	Manufacturer: _____	Addl. Dose Date: ____/____/____				

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