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)	
☐ **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	**Declined**	**Vaccine Lot #**	**Diluent Lot #** (if known)	**Date Vaccine Given or Declined**	**Location of Intramuscular Vaccination** (place X in appropriate box)	
Booster Manufacturer:	☐				**Left Arm** ☐	**Right Arm** ☐
Additional Dose 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 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 Lab Confirmed COVID-19? YES ☐ NO ☐ **Date of most recent lab result:** ____/____/____
Consent for COVID-19 vaccine present in staff member's 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:** ____________ **Booster Date:** ____/____/____
Location: ____________ **Manufacturer:** ____________ **Addl. Dose Date:** ____/____/____

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