VACCINE ADMINISTRATION FORM

Appointment Date:_____ Appointment Time:_____

Legal Name (First and Last):_____ Gender: _____

Age:_____ Birthdate:_____ Employer:_____

Street Address: _____

City, State, Zip: _____

Preferred Phone:_____ Secondary Phone:_____

Email: _____

*Race:
_____American Indian
_____Asian
_____Black
_____White
_____Other

*Ethnicity:
_____Hispanic or Latino
_____Non Hispanic or Latino

Preferred Method of Contact: _____Email _____Text _____Both _____None

Mark All That Apply:
_____Essential Worker _____Long Term Care Employee _____Health Care Worker
_____First Responder _____State/Fed/Tribal Nation Member
_____Medical conditions increasing risk for complications from virus

DISCLOSURE STATEMENT: Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include: shortness of breath, hoarseness of wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes or up to 48 hours after the vaccination. If the recipient is experiencing any of these symptoms, the recipient has been instructed to contact a healthcare provider immediately.

_____***VERBAL CONSENT**: The recipient or legal guardian has been provided the benefits and potential adverse reactions and provides consent to receive the vaccine.

VACCINE ADMINISTRATION INFORMATION

PFIZER LOT:_____ EXPIRATION:_____

MODERNA LOT:_____ EXPIRATION:_____

Vaccine Administration Site: _____LD _____RD _____Other:_____

Notes: _____

_____

Administered By:_____