COVID-19 Vaccine Patient Consent/Vaccine Administration Record

Patient Information

_____

Last Name First Name MI Date of Birth Gender Race/Ethnicity

_____

Address City State Zip

_____

Phone Social Security #

Patient Consent

I understand the benefits and risks of the vaccination as described in the Emergency Use Authorization (EUA) and/or CDC Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine be given to me or the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of Person to Receive Vaccine (or Parent/Guardian, if a minor):

_____ Date: _____

Print Parent/Guardian if recipient is a minor: _____

To be completed by Vaccine Administrator

Vaccine	Date Administered	Vaccine Lot	Expiration Date	MFR	Dosage	Injection Site	VIS/EUA Date	Dose #1 or #2

Administering Immunizer Signature: _____ Date: _____