COVID-19 Vaccination Patient Record

For Documentation in Vaccine Administration Management System (VAMS)

This document facilitates capture of data required for documentation in VAMS

Section I: PATIENT or PATIENT REPRESENTATIVE to complete this section

Today's Date	**First Name** (Print)*	**Last Name** (Print)*	**Gender** (select one)* ☐ Female ☐ Decline to Specify ☐ Male ☐ Other

Date of Birth*	**Race***	**Address**
Ethnicity* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown/Not Reported	**County of Residence**
Tribe of Membership		**Phone**

COVID dose: ☐ 1st dose ☐ 2nd dose	**If 2nd dose, enter date and facility of 1st dose:**
COVID-19 Vaccine Screening Questionnaire completed? ☐ Yes ☐ No	**COVID-19 Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) received?** ☐ Yes ☐ No

Section II: To Be Completed By HEALTHCARE PROFESSIONAL Administering Vaccine

Date COVID-19 vaccine administered:	**Facility/Location:**

COVID-19 Vaccine Screening Questionnaire reviewed and vaccination administration deemed appropriate:

☐ Yes ☐ No ☐ Precaution identified and vaccination in an alternate setting needed

COVID dose: ☐ 1st dose ☐ 2nd dose	**COVID-19 Vaccine Manufacturer:** ☐ Moderna ☐ AstraZeneca ☐ Pfizer ☐ Johnson&Johnson ☐ Novavax ☐ Sanofi Pasteur ☐ Other:	**If 2nd vaccine dose, manufacturer of 1st dose:** ☐ Moderna ☐ AstraZeneca ☐ Pfizer ☐ Johnson&Johnson ☐ Novavax ☐ Sanofi Pasteur ☐ Other:	**Lot Number:** **Expiration:**	**Injection volume:** ☐ 0.3mL ☐ 0.5mL

Immunization site: ☐ Right Deltoid ☐ Right Thigh (peds) ☐ Left Deltoid ☐ Left Thigh (peds)	**Date of Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet:**	**Administration time:**

Was today's vaccination administration successful? ☐ Yes ☐ No If no, is it possible to reattempt administration? ☐ Yes ☐ No	Was any vaccine wasted during administration? ☐ Yes ☐ No **If vaccine wasted select reason:** ☐ Broken Vial/Syringe ☐ Vaccine drawn but not administered ☐ Non-vaccine product (e.g. IG, HBIG, Dil) ☐ Open vial but all doses not administered ☐ Lost or unaccounted for vaccine ☐ Other:
If vaccination was unsuccessful select reason: ☐ Sick or fever ☐ Inventory Shortage ☐ No longer interested ☐ Other: ☐ Staffing ☐ Contraindication identified ☐ _____	

_____ _____

Signature and Title of Vaccinator **Date**

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request.

Signature of Parent/Guardian/Patient_____ **Date**_____