COVID-19 Vaccine Patient Screening/Vaccine Administration Record

Patient Information

Last Name | First Name | Date of Birth | Gender | Phone Number | Last 4 SSN

Address | City | State | Zip

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.

I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and my rights with respect to my health information, including reporting to the State Vaccination Registry and/or local or state Departments of Heath, federal Department of Health and Human Services, and the Center for Disease Control and Prevention.

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

_____ Date: _____

*Print Parent/Guardian name if recipient is a minor:*_____Date: _____

To be completed by Vaccine Administrator

Vaccine	Date Administered	Vaccine Lot#	Expiration Date	MFR	Dosage	Injection Site	VIS/EUA Date	Dose #
COVID-19						Left Arm Right Arm		

Administering Immunizer Signature:_____