**DES MOINES COUNTY PUBLIC HEALTH**

**COVID-19 Vaccine Administration Record**

**Please Print**

**Section 1: Vaccine Recipient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Phone # \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

 Last First M.I

Address:

 Street City State Postal Code

Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_ Age: \_ Gender: [ ]  Male [ ]  Female

Primary Healthcare Provider:

**Section 2: Screening for Vaccine Eligibility**

Has the person listed above previously received COVID-19 vaccine? [ ]  Yes [ ]  No

If yes to above, indicate the COVID-19 vaccine previously received:

 Vaccine Brand Administered (Pfizer, Moderna, Astra Zeneca, Johnson and Johnson):

Date first dose administered: Month Day Year

Date second does administered: Month Day Year

**Section 4: Consent**

I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request.

Signature: Date:

**Healthcare Provider Use Only**

**DOSE 1**

Date Vaccine Administered: Injection Site (Deltoid): [ ]  Left [ ]  Right

Manufacturer: Lot Number: Exp:

Administered by Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOSE 2**

Date Vaccine Administered: Injection Site (Deltoid): [ ]  Left [ ]  Right

Manufacturer: Lot Number: Exp:

Administered by Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dose 1 time**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 15 min / 30 min **Dose 2 time**: \_\_\_\_\_\_\_\_\_\_\_\_\_ 15 min / 30 min