WinnMed

COVID-19 Vaccine Administration Record

Recipient Name: _____
Last First MI

Address: _____
Street City State Postal Code

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Primary Healthcare Provider: _____

Cell phone number: _____

Have you had a severe reaction to a vaccine in the past: Yes _____ No _____
Do you carry an epipen due to severe allergic reaction? Yes _____ No _____

Do you have a compromised immune system? Yes _____ No _____
Do you take medication(s) that suppress your immune system? Yes _____ No _____

I have read the information provided in the Emergency Use Authorization (EUA) Factsheet 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.

Signature: _____ Date _____

Health Care Provider Only

Has the person listed above previously received COVID-19 vaccine? ☐ Yes ☐No
If yes to above, circle the COVID-19 vaccine previously received:
Vaccine Brand Administered (Pfizer, Moderna, Johnson and Johnson)

Date first dose administered: Month_____ Day _____ Year_____
Date second dose administered: Month_____ Day _____ Year_____
Date third dose (immune compromised) administered: Month_____ Day _____ Year_____
Booster dose administered: Month_____ Day _____ Year_____

Injection Site (Deltoid): ☐ Left ☐ Right Lot #: _____

Signature: _____

☐ COVID-19 Vaccine EUA FACT SHEET for recipients provided