106 N. Jackson St, Suite 103, Mt. Pleasant, IA 52641

PFIZER

COVID-19 Vaccine Administration Record

I am: ☐ **6 months to 4 years old** ☐ **5-11 years old** ☐ **12 years or older**

I am here for my: ☐ **1st Dose** ☐ **2nd Dose** ☐ **3rd Dose** (if applicable) ☐ **1st Booster** ☐ **2nd Booster**

Date 1st dose administered: ______________ Circle brand: Pfizer Moderna J & J ________ (Other)

Date 2nd dose administered: ______________ Circle brand: Pfizer Moderna ________ (Other)

Date 1st booster administered: ______________ Circle brand: Pfizer Moderna J & J ________ (Other)

Section 1: Vaccine Recipient Information (Please Print)

Recipient Name: ____
Last First M.I.

Any other last names vaccination records might be under: ______________________________

Address: ____
Street City State Zip Code

Date of Birth:____________ Age:____ Phone Number:________________ ☐ Male ☐ Female

Section 2: Screening for Vaccine Eligibility

Are you immunocompromised (weakened immune system)? ☐ Yes ☐ No

Have you ever had a severe allergic reaction to any vaccination? ☐ Yes ☐ No

If you have previously received the COVID-19 vaccine, did you experience hives, wheezing/respiratory distress, or anaphylaxis within 4 hours of receiving your shot? ☐ Yes ☐ No ☐ N/A

Section 3: 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. **I understand the person receiving the COVID-19 vaccine should remain in the clinic for 15 minutes after the vaccination.**

Signature: ________________________________ Date: ______________

Links to the COVID-19 Vaccine EUA Fact Sheets for Recipients are referenced on the CDC handout you received today and hard copies of the fact sheets are available upon request.

Healthcare Provider Use Only

Date Vaccine Administered: ________________ Injection Site (Deltoid): ☐ Left ☐ Right

Manufacturer: Lot #______________Exp: ________ Administered by: ____________