Floyd Valley Healthcare

COVID-19 Vaccine Administration Record

PLEASE COMPLETE ALL SECTIONS

Section 1: Vaccine Recipient Information

Recipient Name: _____
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 3: Insurance

Please provide medical insurance information for the vaccine recipient.

Insurance Name: _____ Member ID: _____

Social Security Number: _____ Cardholder Name: _____

Relationship to Vaccine Recipient: _____

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 Below This Line

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

Manufacturer: **Moderna** Lot Number:_____ Exp: _____

Administered by Print: _____ Signature: _____

☐ COVID-19 Vaccine EUA FACT SHEET for Recipients provided