Vaccine Administration Worksheet

Recipient Information

**Required Fields*

***Recipient Full Name:** _____ (*First* / *Last*)

***Recipient Date of Birth:** ____ / ____ / ____ (*Month* / *Day* / *Year*)

***Recipient Email:** _____

***Recipient Home Phone #:** _____ **Recipient Mobile Phone #:** _____

***Recipient Address:**

***Street Name:** _____ ***City:** _____

***County:** _____ ***State:** _____ ***Zip Code:** _____ ***Country:** _____

***Recipient Race:**

____ American Indian or Alaska Native
____ Asian
____ Black or African American
____ White
____ Other Race

***Recipient Ethnicity**

____ Hispanic or Latino
____ Not Hispanic or Latino

***Recipient Gender**

____ Male
____ Female
____ Unknown

***Preferred Method of Contact**

____ Email**
____ SMS**
____ Both**
____ None

**Please ensure the selected method of contact is populated above accordingly.*

Vaccination Consent

DISCLOSURE STATEMENT: Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include: shortness of breath, hoarseness of wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes or up to 48 hours after the vaccination. If the recipient is experiencing any of these symptoms, the recipient has been instructed to contact a healthcare provider immediately.

____ ***VERBAL CONSENT: The recipient or legal guardian has been provided the benefits and potential adverse reactions, and provides consent to receive the vaccine.**

Administering Site Information

** Required Fields*

***Responsible Organization:** _____

"Responsible Organization" is the name of the parent organization or health system that originated and is accountable for the content of the record. If an organization has several clinics or facilities, this would be the organization that represents all of the clinics/facilities.

***Administration at Location:** _____

"Administration at Location" is the name of the physical clinic or facility that reported the vaccination, refusal, or missed appointment. In a small practice setting, this could be the same as the responsible organization.

Vaccine Administration Information

**Required Fields*

***Administration Date:** ____ / ____ / ____ (*Month* / *Day* / *Year*)

***Administration Time:** _____ : _____ ____ AM ____ PM

***Vaccine Expiration Date:** ____ / ____ / ____ (*Month* / *Day* / *Year*)

***Vaccine Barcode:** _____

***Vaccine Type (CVX):** _____

***Vaccine Manufacturer (MVX):** _____

***Vaccine Product (NDC):** _____

***Vaccine Lot Number:** _____

***Available Vaccine Inventory:** _____

***Vaccine administered on behalf of (Clinician):**

***Vaccine Administering Site**

____ Left Deltoid (LD)
____ Left Arm (LA)
____ Left Lower Forearm (LLFA)
____ Right Deltoid (RD)
____ Right Arm (RA)
____ Right Lower Forearm (RLFA)
____ Left Thigh (LT)
____ Left Gluteus Medius (LG)
____ Left Vastus Lateralis (LVL)
____ Right Thigh (RT)
____ Right Gluteus Medius (RG)
____ Right Vastus Lateralis (RVL)

***Vaccine Route of Administration**

____ Intradermal (IM)
____ Subcutaneous (SQ)

***Dose Number**

____ First Dose
____ Second Dose

Notes:

_____
_____
_____
_____

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**Required Fields*

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