Wallowa Memorial Hospital

COVID-19 Vaccine Administration Record

Section 1: Vaccine Recipient Information

Recipient name: _____
Last name First name M.I.

Address: _____
Street City State ZIP

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

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: _____

Section 3: Screening Questionnaire

Are you feeling sick today?	**YES** ☐	**NO** ☐
Have you been treated with antibody therapy for COVID-19 in the past 90 days?	**YES** ☐	**NO** ☐
Have you had a serious or life-threatening allergic reaction, such as hives, or difficulty breathing to *any* vaccine or shot?	**YES** ☐	**NO** ☐
Have you had any vaccines in the past 14 days? (Including flu shot)	**YES** ☐	**NO** ☐
Are you pregnant, considering becoming pregnant or breast feeding?	**YES** ☐	**NO** ☐
Do you have cancer, leukemia, HIV/AIDS, history of autoimmune disease or any other conditions that weakens the immune system?	**YES** ☐	**NO** ☐
Do you take any medications that affect your immune system such as steroids, anticancer drugs or have you had any radiation treatments?	**YES** ☐	**NO** ☐

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. I understand that this is a 2 part vaccine and I will need to receive the 2nd dose in 28 days for the vaccine to be fully effective.

Signature: _____ Date: _____

Healthcare Provider Use Only

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

Manufacturer: _____ Lot number: _____ Exp: _____

Administered by print: _____

Signature: _____