

<Insert facility logo>

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|  | **Staff Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.:\_\_\_/\_\_\_/\_\_\_ Start Date:\_\_\_/\_\_\_/\_\_\_ End Date:\_\_\_/\_\_\_/\_\_\_****Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Consent for COVID-19 vaccine present in staff member’s record? YES** ¨  **NO** ¨  |
| **Education (including benefits & potential side effects) Provided to Staff:** | **COVID-19 Vaccine** (1st dose) **Education Date \_\_\_/\_\_\_/\_\_\_** Initials \_\_\_\_\_\_**COVID-19 Vaccine** (2nd dose) **Education Date \_\_\_/\_\_\_/\_\_\_** Initials \_\_\_\_\_\_**Vaccine** (additional dose or booster) **Education Date \_\_\_/\_\_\_/\_\_\_** Initials \_\_\_\_**Vaccine** (additional dose or booster) **Education Date \_\_\_/\_\_\_/\_\_\_** Initials \_\_\_\_\_\_**Vaccine** (additional dose or booster) **Education Date \_\_\_/\_\_\_/\_\_\_** Initials \_\_\_\_\_\_ |
| **2.** | **Manufacturer of Vaccine**(place X in appropriate box) | **Dose of Vaccine**(check correct mL dosage) | **Declined**(indicate dose in appropriate box) | **Vaccine Lot #** | **Diluent Lot #** (if known) | **Date Vaccine Given or Declined** | **Location of Intramuscular Vaccination**(place X in appropriate box) |
| **Pfizer** ¨\*3 weeks recommended between doses | 1. ¨ | 1. ¨ |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| 2. ¨ | 2. ¨ | **Left Arm** ¨ | **Right Arm** ¨ |
| **Moderna** ¨\*4 weeks recommended between doses | 1. ¨ | 1. ¨ |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| 2. ¨ | 2. ¨ | **Left Arm** ¨ | **Right Arm** ¨ |
| **Janssen/J&J** ¨ | 1. ¨ | 1. ¨ |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| **Other** ¨**(Print name)** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 1. ¨ | 1. ¨ |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| 2. ¨ | 2. ¨ | **Left Arm** ¨ | **Right Arm** ¨ |
| **3.** | **Vaccine Type**(Refer to the [CDC’s website](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html) for recommendations on booster dose versus additional dose) | **Declined** | **Vaccine Lot #** | **Diluent Lot #** (if known) | **Date Vaccine Given or Declined** | **Location of Intramuscular Vaccination**(place X in appropriate box) |
|  | **Manufacturer:** | ¨ |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| **Manufacturer:** | ¨ |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| **Manufacturer:** | ¨ |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| **4.** | **Contraindication:** Immediate allergic reaction of *any* severity to previous COVID-19 vaccine; reaction to polysorbate, or polyethelene glycol. **Refer staff member to allergist/immunologist for COVID-19 vaccine evaluation.** **Contraindication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Adverse Event (Reaction) to Current Vaccine Administration** -Describe any reaction to vaccine**:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Refer to the [CDC’s website](https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html) for information on contraindications and adverse events. |
| **5.** |
| **6.** |  **Check Box if COVID-19 Vaccine, Booster, or Additional Dose Received at Another Setting:** ¨ **Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose 1 Date: \_\_\_/\_\_\_/\_\_\_** **Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose 2 Date: \_\_\_/\_\_\_/\_\_\_** **Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose Date: \_\_\_/\_\_\_/\_\_\_** **Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose Date: \_\_\_/\_\_\_/\_\_\_** **Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose Date: \_\_\_/\_\_\_/\_\_\_** |
| **7.** |  **History of Confirmed COVID-19? YES** ¨  **NO** ¨ **If yes,** **date of most recent result: \_\_\_\_/\_\_\_\_/\_\_\_\_** |



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[**www.ahrq.gov**](http://www.ahrq.gov)

**Staff COVID-19 Vaccine Administration Record**

*This tool is voluntary and not related to any interim, final, or enjoined Centers for Medicare & Medicaid Services (CMS) rules or regulations related to nursing homes.*