

# COVID-19 VACCINE ADMINISTRATION RECORD (VAR)

**Information About Person Receiving Vaccine:**

First Name: (Print)	Middle Name:	Last Name:	Mothers Maiden:
DOB:	Age:	Gender:	Race:
Name (Parent or Guardian if applicable)		Phone (Include area code)	Cell Phone (include area code)

Address:	City:	State:	Zip:
County:	Email:		

Prior to administration of the vaccine(s) indicated below, a copy of the Emergency Use Agreement Fact Sheet and a Vaccine Information Statement for each vaccine was provided to me. I was given the opportunity to ask questions regarding the EUA and the vaccine(s) and agree to its administration.

Signature of Parent/Guardian or adult vaccine recipient \_\_\_\_\_

### FOR CLINIC USE ONLY

Prior to administration of the vaccine(s) indicated below, a copy of the Emergency Use Agreement Fact Sheet and a Vaccine Information Statement was provided to the client or representative for whom the vaccine was administered. The client or his/her representative was given the opportunity to ask questions regarding the EUA and the vaccine(s).

Clinic:	Date Vaccinated:	Signature & Title of Vaccine Administrator:

**Vaccine:** \_\_\_\_\_

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Manufacturer \_\_\_\_\_ Lot Number \_\_\_\_\_

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Injection Site \_\_\_\_\_ Route \_\_\_\_\_

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VIS Pub Date \_\_\_\_\_ Dose 1 2 3

**Vaccine:** \_\_\_\_\_

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Manufacturer \_\_\_\_\_ Lot Number \_\_\_\_\_

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Injection Site \_\_\_\_\_ Route \_\_\_\_\_

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VIS Pub Date \_\_\_\_\_ Dose 1 2 3

**Vaccine:** \_\_\_\_\_

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Manufacturer \_\_\_\_\_ Lot Number \_\_\_\_\_

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Injection Site \_\_\_\_\_ Route \_\_\_\_\_

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VIS Pub Date \_\_\_\_\_ Dose 1 2 3

**Vaccine:** \_\_\_\_\_

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Manufacturer \_\_\_\_\_ Lot Number \_\_\_\_\_

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Injection Site \_\_\_\_\_ Route \_\_\_\_\_

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VIS Pub Date \_\_\_\_\_ Dose 1 2 3