

COVID-19 VACCINE PATIENT INFORMATION SHEET

First name: _____

Middle name: _____

Last name: _____

DOB: _____ GENDER: male or female (circle)

Race & Ethnicity: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

Primary phone number: _____

VACCINE ADMINISTRATION INFORMATION

Lot # _____ Expiration date: _____

CVX code: _____ MVX code: _____

Date administered: _____ Route: _____

Site given: RD (right deltoid) or LD (Left deltoid) – please circle

Vaccine administered by: _____