COVID-19 Vaccination Employee Record

Section I: EMPLOYEE to complete this section

Date	**First Name** (Print)	**Last Name** (Print)
Date of Birth	**Address**	**County of Residence**
		Phone

Enter date and facility of latest previous COVID vaccine dose if applicable:

COVID-19 Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) received? ☐ Yes ☐ No

☐ **Employee** ☐ **Personal Services Contractor** ☐ **Volunteer** ☐ **Resident/Student** ☐ **Independent Contractor** ☐ **Other** _____	**Facility:** **Department:**

Section II: To Be Completed By HEALTHCARE PROFESSIONAL Administering Vaccine

Date COVID-19 vaccine administered:	**Facility/Location:**

COVID-19 Vaccine Prevaccination Checklist reviewed and vaccination administration deemed appropriate:
☐ Yes ☐ No ☐ Precaution identified and vaccination in an alternate setting needed

☐ **Moderna** (Blue label) ☐ Vial, Single Dose, 50 mcg/0.5 mL
12 yrs and older ☐ Syringe, Pre-Filled, 50 mcg/0.5 mL

☐ **Pfizer** (Gray Cap) ☐ Vial, Single Dose, 30 mcg/0.3 mL
12 yrs and older ☐ Syringe, Pre-Filled, 30 mcg/0.3 mL

☐ **Novavax** ☐ Vial, Multi-Dose, 5 mcg/0.5 mL
12 years and older

Lot Number:	**Expiration:**	**Administration time:**	**Date of Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet:**

Immunization site: ☐ Right Deltoid ☐ Left Deltoid

Assessment after injection:
☐ Individual left before assessment completed
☐ Individual assessed after 15 minutes
☐ No reaction noted
☐ Individual assessed after 30 minutes (history of anaphylaxis or reactions)
☐ No reaction noted

☐ COVID vaccination documentation completed in Patient Medical Record (if IHS Form 810 is completed)

_____ _____

Signature and Title of Vaccinator **Date**

Instructions for Completing COVID-19 Vaccination Employee Record

Purpose of form:

1. Captures required data for documentation of vaccination
2. Serves as a record of COVID-19 vaccine administered to EMPLOYEE

Form instructions:

1. Print legibly in all fields using dark permanent ink
2. Section I, to be completed by EMPLOYEE
3. Section II, to be completed by HEALTHCARE PROFESSIONAL who administers vaccine
4. Completed form to be placed in Employee Medical File
5. If IHS-810 completed for disclosure to patient record, document vaccine as a historical record in RPMS