COVID-19 Vaccination Form **12 years and older**
For documentation in RPMS EHR
Use of form is not necessary if documenting vaccine in RPMS EHR at point of service
Use of form is optional based on determined local workflow

Section I: PATIENT or PATIENT REPRESENTATIVE to complete this section

Date:	Last Name (Print):	First Name (Print):	Middle Name (Print):

Date of Birth:	Chart Number (if known):	Allergies/Adverse Drug Reactions: ☐ NONE

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

Section II: To Be Completed By HEALTHCARE PROFESSIONAL Administering Vaccine

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

Immunization site: ☐ Right Deltoid   ☐ Left Deltoid

☐ **Moderna** (Blue Label) **12 yrs and older**	☐ Vial, Single Dose, 50 mcg/0.5 mL ☐ Syringe, Pre-Filled, 50 mcg/0.5 mL
☐ **Pfizer** (Gray Cap) **12 yrs and older**	☐ Vial, Single Dose, 30 mcg/0.3 mL ☐ Syringe, Pre-Filled, 30 mcg/0.3 mL
☐ **Novavax** **12 years and older**	☐ Vial, Multi-Dose, 5 mcg/0.5 mL

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

Administration notes:

☐ **Vaccine literature provided**   Education duration (minutes): _____

☐ **Information given on benefits, side effects, post immunization care**   Education duration (minutes): _____

☐ **Provided information on following the required schedule for vaccinations**   Education duration (minutes): _____

Level of Understanding: ☐ Good ☐ Fair ☐ Poor   **Readiness to Learn:**   ☐ Receptive

Comments: ☐ Other:

Assessment after injection:	Return Date (if applicable):
☐ Patient left before assessment completed ☐ Patient assessed after 15 minutes ☐ No reaction noted	
☐ Patient assessed after 30 minutes (history of anaphylaxis or reactions) ☐ No reaction noted	☐ COVID vaccination documentation completed in EHR

_____   _____

Signature and Title of Vaccinator   **Date**

Instructions for Completing

COVID-19 Mass Vaccination Form for documentation in RPMS EHR

Purpose of form:
1. Capture patient vaccine information during mass vaccination events, off-site vaccination events, or during other times when it is not feasible to capture vaccination at the point of service
2. Use of form is not necessary if vaccine administration is captured in RPMS EHR at the point of service

Form instructions:
1. Print legibly in all fields using dark permanent ink
2. Section I, to be completed by PATIENT or PATIENT REPRESENTATIVE
3. Section II, to be completed by HEALTHARE PROFESSIONAL who administers vaccine
4. Information from form is to be electronically recorded in RPMS EHR