

# COVID-19 Vaccination Form \*\*PEDIATRICS Less Than 12 years\*\*

## 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:	<input type="checkbox"/> 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

Injection site: ☐ Right Deltoid ☐ Left Deltoid ☐ Right Thigh (peds 2 yrs and under) ☐ Left Thigh (peds 2 yrs and under)

#### Moderna Vaccines 6 months through 11 years

☐ Moderna (Dark Blue Cap, Green Label) ☐ Vial, Single Dose, 25 mcg / 0.25 mL

6 MONTHS through 11 years

#### Pfizer Vaccines 6 months through 11 years

☐ Pfizer (Yellow Cap) ☐ Vial, Multi Dose, 3mcg / 0.3 mL

6 MONTHS through 4 years

☐ Pfizer (Blue Cap) ☐ Vial, Single Dose, 10 mcg / 0.3 mL

5 years through 11 years

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

☐ 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

Return Date (if applicable):

☐ 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 HEALTHCARE PROFESSIONAL who administers vaccine
4. Information from form is to be electronically recorded in RPMS EHR