

<Insert facility logo>

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Resident Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| **Unit and Room #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_ Admission Date: \_\_/\_\_/\_\_ Discharge Date: \_\_/\_\_/\_\_** | | | | | | | | |
| **Consent for COVID-19 vaccine present in resident’s record? YES** ¨ **NO** ¨ | | | | | | | | |
| **Education (including benefits & potential side effects) Provided to Resident/Responsible Party:** | | | **COVID-19 Vaccine** (1st dose) **Education Date \_\_\_/\_\_\_/\_\_\_** Initials \_\_\_\_  **COVID-19 Vaccine** (2nd dose) **Education Date \_\_\_/\_\_\_/\_\_\_** Initials \_\_\_\_  **Vaccine** (additional dose or booster) **Education Date \_\_/\_\_/\_\_** Initials \_\_\_\_ **Vaccine** (additional dose or booster) **Education Date \_\_\_/\_\_\_/\_\_\_** Initials \_\_\_\_\_  **Vaccine** (additional dose or booster) **Education Date \_\_\_/\_\_\_/\_\_\_** Initials \_\_\_\_\_ | | | | | |
| **2.** | **Manufacturer of Vaccine**  (place X in appropriate box) | **Dose of Vaccine** (check correct mL dosage) | **Declined**  (indicate dose in appropriate box) | | **Vaccine Lot #** | **Diluent Lot #**  (if known) | **Date Vaccine Given or Declined** | **Location of Intramuscular Vaccination**  (place X in appropriate box) | |
| **Pfizer** ¨  \*3 weeks recommended between doses | 1. ¨ | 1. ¨ | |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| 2. ¨ | 2. ¨ | | **Left Arm** ¨ | **Right Arm** ¨ |
| **Moderna** ¨  \*4 weeks recommended between doses | 1. ¨ | 1. ¨ | |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| 2. ¨ | 2. ¨ | | **Left Arm** ¨ | **Right Arm** ¨ |
| **Janssen/J&J** ¨ | 1. ¨ | 1. ¨ | |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| **Other** ¨  **(Print name)**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 1. ¨ | 1. ¨ | |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| 2. ¨ | 2. ¨ | | **Left Arm** ¨ | **Right Arm** ¨ |
| **3.** | **Vaccine Type** (Refer to the [CDC’s website](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html) for recommendations on booster dose versus additional dose) | | **Declined** | | **Vaccine Lot #** | **Diluent Lot #** (if known) | **Date Vaccine Given or Declined** | **Location of Intramuscular Vaccination** (place X in appropriate box) | |
|  | **Manufacturer:** | | ¨ | |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| **Manufacturer:** | | ¨ | |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
|  | **Manufacturer:** | | ¨ | |  |  |  | **Left Arm** ¨ | **Right Arm** ¨ |
| **4.** | **Contraindication**: Immediate allergic reaction of any severity to previous COVID-19 vaccine; reaction to polysorbate, or   polyethelene glycol. **Refer to allergist/immunologist for COVID-19 vaccine evaluation.   Contraindication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Adverse Event (Reaction) to Current Vaccine Administration –** Describe any reaction to vaccine:   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Refer to the [CDC’s website](https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html) for information on contraindications and adverse events. | | | | | | | | |
| **5.** |
| **6.** | **Check Box if COVID-19 Vaccine, Booster, or Additional Dose Received at Another Setting:** ¨  **Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose 1 Date: \_\_\_/\_\_\_/\_\_\_**  **Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose 2 Date: \_\_\_/\_\_\_/\_\_\_**  **Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose Date: \_\_\_/\_\_\_/\_\_\_**  **Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose Date: \_\_\_/\_\_\_/\_\_\_**  **Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose Date: \_\_\_/\_\_\_/\_\_\_** | | | | | | | | |
| **7.** | **History of Confirmed COVID-19? YES** ¨ **NO** ¨ **If yes,** **date of most recent result: \_\_\_\_/\_\_\_\_/\_\_\_\_** | | | | | | | | |



*This tool is voluntary and not related to any interim, final, or enjoined Centers for Medicare & Medicaid Services (CMS) rules or regulations related to nursing homes.*

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**Resident COVID-19 Vaccine Administration Record**