

COVID-19 Vaccine Administration Record CHILDREN ONLY

My child is: Age 5-11 Age 1	2-18		
My child is getting: ☐ 1 st Dose ☐] 2 nd Dose		
If 2 nd dose, date 1 st dose was administer	red: Month	Day	Year
Section 1: Vaccine Recipient Inforn	nation (Please Print)		
Recipient Name:	First	M.I.	
Address:			
Date of Birth:	Age:	Gender: Mal	
Phone Number:	Primary Physician:		_
Section 2: Screening for Vaccine Eli	igibility		
Has the person listed above ever had a severe allergic reaction to any vaccination? Yes No			
Has the person listed received passive antibody therapy as treatment for COVID-19? Yes No			
If the child has previously received the COVID-19 vaccine, did they experience hives, wheezing/respiratory distress, or anaphylaxis within 4 hours of receiving their shot? Yes No N/A			
Section 3: Consent			
I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request. I understand the person receiving the COVID-19 vaccine should remain in the clinic for 15 minutes after the vaccination.			
Signature:		Date:	
Links to the COVID-19 Vaccine EUA Fact Sheets for Recipients are included on the CDC handout you received today and hard copies of the fact sheets are available upon request.			
Healthcare Provider Use Only			
Date Vaccine Administered:	Injection Site (Deltoid): Left Right		
	Manufacturer: Pfizer	Dosage: Chil	ld
Lot #	Exp:	Administered by:	

Iowa Wesleyan University 601 N. Main St. Mt. Pleasant, IA 52641 Calvary Baptist Church 803 E. Maple Leaf Dr. Mt. Pleasant, IA 52641 First Presbyterian Church 902 S. Walnut St. Mt. Pleasant, IA 52641