COVID-19 VACCINE PATIENT INFORMATION

First name:____

Middle name: ____

Last name: ____

DOB: ____________ GENDER: male or female (circle)

Race & Ethnicity: ____

Street Address:____

City: ___________________________ County: __________________

State: __________________________ Zip Code: ________________

Primary phone number: ____________________________________

VACCINE ADMINISTRATION INFORMATION

Lot # ____________________ Expiration date: ___________________

CVX code: ________________ MVX code: _______________________

Date administered: __________________ Route: __________________

Site given: RD (right deltoid) or LD (Left deltoid) – please circle

Vaccine administered by: __________________________________