Roane General Hospital
Care you can trust. . .close to home

Covid-19
VACCINE ADMINISTRATION RECORD

Name: (First Middle Last)		**Birthday:**	**XXX-XX - _____**	
Address:	**City:**	**State:**	**Zip:**	
Email Address:			Race:	Ethnicity:
Cell Number:	Home Number:	Preferred Contact:	Sex:	Dose: □ 1st □ 2nd
Have you ever had any Covid vaccine? □ Yes □ No				
Have you ever had a reaction to any Covid vaccine? □ Yes □ No				
Have you had any changes since the last Covid vaccine? □ Yes □ No (If first dose was with Roane General Hospital and no changes since dose, skip below questions and sign form.)			Emergency Contact: Name/ Phone #:	
Allergies: □ No existing or known allergies □ Milk □ Fish (e.g., bass, flounder, cod) □ Eggs □ Peanuts □ Wheat □ Soybeans □ Tree nuts (e.g. almonds, walnuts, pecans) □ Crustacean shellfish (e.g. crab, lobster, shrimp) □ Latex □ Gelatin/ egg protein □ Yeast □ Neomycin □ Thimerosal □ Other				
Known existing medical conditions: □ No existing conditions □ Asthma □ Sickle Cell disease □ Serious heart disease □ Liver disease □ Chronic lung disease □ Chronic Kidney disease □ Diabetes □ Severely Obese □ Immunocompromised				
Are you currently living in a nursing home? □ Yes □ No				
Do you use an epinephrine auto injector (Epi pen) for your allergies? □ Yes □ No				
Have you ever had a reaction to any vaccine? □ Yes □ No				
Have you ever had an anaphylactic allergic (swelling of your lips, tongue, face, or stopped breathing) reaction? □ Yes □ No				
Are you: □Pregnant □ Planning to become pregnant in the next 3 months □ breast feeding □ had a baby within the last 3 months □ N/A				
Do you currently have any symptoms that would indicate that you have an active infection? □ Yes □ No				

I have read or have had explained to me the information with this form (***Fact Sheet for Recipients and Caregivers)*** about the Covid-19 vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of Covid-19 vaccine and request that the vaccine named above is given to me or to the person named above for whom I am authorized to make this request. ***I authorize administration of the vaccine.***

X_____ Date_____

Clinic/Office Use

Date Administered: _____ Manufacturer: _____

Manufacturer Sticker

Product Name: _____ Lot Number: _____ Exp. Date: _____

Route of Administration: _____ Site of Injection: _____ EUA Date: 12/2020

Time of Injection: _____Post monitoring time:15 minutes unless history of anaphylactic reaction then 30 minutes

Signature of Vaccine Administrator: _____