COVID-19 Vaccine

+12 Dose Administration Tool

CLIENT INFO		
LAST NAME		FIRST & MIDDLE NAMES
DOB YYYY/MM/DD	AGE	HEALTH CARD NUMBER
EMAIL ADDRESS		

FOR CLINIC USE ONLY

PREVIOUS VACCINE		
PREVIOUS VACCINE NAME	# DAYS SINCE LAST DOSE	TODAY'S DOSE #

PRE-SCREENING QUESTIONS		
1. Acute Illness / Previous COVID infection within 6 months	YES	NO
2. Allergic reaction to: a. Any previous vaccines (COVID or routine) b. Injectable medications c. PEG, tromethamine and/or polysorbate allergies	YES	NO
3. Myocarditis or pericarditis following COVID-19 vaccines	YES	NO
4. Weakened immune system/Immunosuppressant medications or treatments	YES	NO
5. Received an Imvamune vaccine (Monkey Pox) in the last 4 weeks	YES	NO
6. Received an Arexvy vaccine (RSV) in the last 2 weeks	YES	NO
7. Bleeding disorder / blood thinning medications	YES	NO
8. History of fainting	YES	NO

COMMENTS	PREVIOUS AEFI

DOSE ADMINISTERED

MONOVALENT PFIZER XBB.1.5	MONOVALENT MODERNA XBB.1.5
Lot #: ________________ Dose: 30 mcg	Lot #: ________________ Dose: 50 mcg
Route: IM Dose #: **1 2 Booster**	Route: IM Dose #: **1 2 Booster**
Site: **Left** OR **Right** Deltoid	Site: **Left** OR **Right** Deltoid
Date Given: ______________________Time: ______	Date Given: ______________________Time: ________
Given By: _________________________________	Given By: _________________________________

☐ **Dose Administered in COVax**