COVID-19 Vaccine
Age 6 months to <5 Years Dose Administration Tool

CLIENT INFO			
LAST NAME		FIRST & MIDDLE NAMES	
DOB YYYY/MM/DD	AGE	HEALTH CARD NUMBER	
SCHOOL		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. Any previous history of: a. Myocarditis or pericarditis b. Multisystem Inflammatory Syndrome in Children (MIS-C)	**YES**	**NO**
4. Weakened immune system/Immunosuppressant medications or treatments	**YES**	**NO**
5. Bleeding disorder / Blood thinning medications	**YES**	**NO**
6. History of fainting / Needle fear	**YES**	**NO**

COMMENTS	PREVIOUS AEFI

DOSE ADMINISTERED:

MONOVALENT PFIZER XBB.1.5	MONOVALENT MODERNA XBB.1.5
Lot #: ________________ Dose: 3 mcg	Lot #: ________________ Dose: 25 mcg
Route: IM Dose #: **1 2 3 Booster**	Route: IM Dose #: **1 2 Booster**
Site: **Left** OR **Right**	Site: **Left** OR **Right**
Deltoid OR **Vastus Lateralis**	**Deltoid** OR **Vastus Lateralis**
Date Given: __________________Time:____________	Date Given: __________________Time:____________
Given By: _________________________________	Given By: _________________________________

☐ **Verbal Consent Obtained from Parent, Legal Guardian, or Substitute Decision Maker**

____ ____

(FIRST AND LAST NAME OF LEGAL GUARDIAN) **(RELATIONSHIP TO CLIENT)**

☐ **Dose Administered in COVax**