COVID-19 VACCINE PATIENT INFORMATION SHEET

First name:	
Middle name:	
Last name:	
DOB: GENDER: m	nale or female (circle)
Race & Ethnicity:	
Street Address:	
City: County:	
State: Zip Cod	le:
Primary phone number:	
VACCINE ADMINISTRATION INFORMATION	
Lot # Expiration date: _	
CVX code: MVX code:	
Date administered: Route	e:
Site given: RD (right deltoid) or LD (Left deltoid) – please circle	
Vaccine administered by:	
Race & Ethnicity: County: City: County: State: Zip Cod Primary phone number: VACCINE ADMINISTRATION INFO Lot # Expiration date: CVX code: MVX code: Date administered: Route Site given: RD (right deltoid) or LD (Left deltoid)	in the second of