COVID Vaccine Details Form

About You

Name:

Workplace:

Are you Pregnant? Yes ◯ No ◯

Do you currently have any illnesses? (ie: Fever, Coughing, Aches, Extreme Fatigue, etc.) Yes ◯ No ◯

What:

Prescription / Drug Allergies:

About the Vaccination (Ask healthcare professional to help fill out this section)

Vaccination Site:

Date of Vaccination:

Time of Vaccination:

Vaccine Manufacturer:

Vaccine Lot Number:

Dosage (ie: 3mL, 5mL, etc.):

2nd Shot Required? Yes ◯ No ◯

How long is this vaccine good for?

When?

Professional who administered vaccine:

Contact information for questions if reactions develop:

Have all manufacturer's procedural requirements been followed in the delivery, storage, and preparation of the vaccine for administration? Yes ◯ No ◯ (If No, request a different time for vaccination)

CSEA is providing this vaccination details form for Member information. It is designed to help the member ask relevant questions of the healthcare professional administering the vaccine and to establish a personal record of vaccination.