

COVID-19 VACCINE ADMINISTRATION RECORD (VAR)

Information About Person Receiving Vaccine:			LAST 4 of Social Security Number:	
First Name: (Print)	Middle Name:	Last Name:	Mothers Maiden:	
DOB:	Age:	Gender:	Race:	Ethnicity:
Name (Parent or Guardian if applicable)			Phone (Include area code)	Cell Phone (include area code)

Address:	City:	State:	Zip:
County:	Email:		

Prior to administration of the vaccine(s) indicated below, a copy of the Emergency Use Agreement Fact Sheet and a Vaccine Information Statement for each vaccine was provided to me. I was given the opportunity to ask questions regarding the EUA and the vaccine(s) and agree to its administration.

Signature of Parent/Guardian or adult vaccine recipient _____

FOR CLINIC USE ONLY

Prior to administration of the vaccine(s) indicated below, a copy of the Emergency Use Agreement Fact Sheet and a Vaccine Information Statement was provided to the client or representative for whom the vaccine was administered. The client or his/her representative was given the opportunity to ask questions regarding the EUA and the vaccine(s).

Clinic:	Date Vaccinated:	Signature & Title of Vaccine Administrator:
University of Mississippi		PharmD

Vaccine: COVID-19	
___ PFIZER ___ ___ Manufacturer	___ FH8028 ___ ___ Lot Number
___ LA ___ RA ___ Injection Site	___ IM ___ Route
VIS Pub Date ___ 10/20/2021 ___ Dose 1 2 3	

Vaccine: _____	
_____ Manufacturer	_____ Lot Number
_____ Injection Site	_____ Route
VIS Pub Date _____ Dose 1 2 3	

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