

Last Name

Grid for Last Name (12 boxes)

First Name

Grid for First Name (12 boxes)

Date of Birth

Date of Birth grid (MM/DD/YYYY)

Dose Number 1 2

STOP: DO NOT WRITE BELOW THIS LINE-FOR CLINIC STAFF ONLY

COVID/VFC PIN <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Provider Type <input type="checkbox"/> Public <input type="checkbox"/> Private	Clinic Name <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Provider Name <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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Manufacturer <input type="checkbox"/> PFR (Pfizer) <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> Janssen	Lot Number <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dosage <input type="checkbox"/> 0.3 ml <input type="checkbox"/> 0.5 ml	Site <input type="checkbox"/> LD <input type="checkbox"/> LT <input type="checkbox"/> RD <input type="checkbox"/> RT	Date Administered <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> M M D D Y Y Y Y
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Administered by:
Name _____ Title _____