Dakota
Natural Health Center

COVID-9 Vaccine Administration Record

The facility may keep this record on file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and the title of the person who gave the vaccine, and the address where the vaccine was given.

1st Dose _____ Date:_____ 2nd Dose _____ Date_____

Information about the person to receive vaccine (Please PRINT). **ALL info is needed to submit insurance if applicable.**					
Last Name	**First Name (Formal)**		**Middle Initial**	**Birthdate**	**Age**
Address	**City**	**State**	**Zip**	**County**	
Hm Phone #		**Wk Phone #**			
Allergies to other vaccines: _____ Yes _____ No **Signature of person to receive vaccine or person authorized to make request (parent or guardian)**					
X _____ Date_____					

For Clinic/Office Use

Clinic/Office & Address: Dakota Pharmacy 701-255-1881
Dakota Natural Health Center 701-258-9418
705 E. Main Ave.Bismarck, ND 58501

1st Dose Info:

Date of Vaccination:_____ Site of Injection:_____

Manufacturer:_____ Place of administration:_____

Vaccine Lot Number:_____ Signature & Title of Vaccine Administrator:

_____

Priority Groups for COVID Vaccine (Select all that apply):

- ☐ Healthcare personnel (i.e. paid and unpaid personnel working in healthcare settings, local public health personnel, long term care staff)
- ☐ Long-term care resident
- ☐ Essential worker (i.e. emergency medical services, education, fire, law enforcement, utility, energy, etc.)
- ☐ Adult aged 65 years or older
- ☐ Underlying health condition (i.e. COPD, heart disease, diabetes, chronic kidney disease, obesity)
- ☐ Live-in other congregate setting
- ☐ Unknown

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any of the following questions, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain.

Question	Yes	No	Unknown
Have you had a severe allergic reaction (e.g., anaphylaxis) to a previous vaccine or other injectable therapy?	If yes, please specify:		
Have you had a severe allergic reaction (e.g., anaphylaxis) to food, medicine, or other?	If yes, please specify:		
Have you received any vaccines in the past fourteen days?			
Have you tested positive for COVID-19?	If yes, when?		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment within the past 90 days?			
Do you currently have a fever?			
Do you have a bleeding disorder or are on a blood thinner?			
Are you pregnant, planning to become pregnant or breastfeeding?			

2nd Dose Info

DO NOT WRITE BELOW THIS LINE

✓	COVID Vaccine Presentation	EUA Fact Sheet Date	Route[1]	Manufacturer[2]	Lot Number	Admin Site[3]	Person Admin[4]
	COVID-19 (Pfizer)		IM	PFR			
	COVID-19 (Moderna)		IM	MOD			

Signature and Title of Person Administering Vaccine:	Date Administered:

1. **Route:** IM = Intramuscular
2. **Manufacturer:** MOD = Moderna, PFR = Pfizer
3. **Site Vaccine Given:** LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh
4. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines