Wilmington Health
1202 Medical Center Drive, Wilmington, NC 28401
Phone: (910) 407-5115
www.wilmingtonhealth.com

VACCINATION ADMINISTRATION WORKSHEET

Required Fields/Please Print Information:

Recipient First Name: _____ **Recipient Phone #**: _____
Recipient Last Name: _____
Recipient Date of Birth: _____
Month Day Year

Recipient Email: _____
Recipient Address: _____
City_____**County**_____**State**_____
Zip Code_____**Country** _____

Recipient Race: ☐Asian ☐Black/African American ☐ American Indian or Alaskan Native ☐White ☐ Other Race
Recipient Ethnicity: ☐Not Hispanic or Latino ☐ Hispanic or Latino
Recipient Gender: ☐ Male ☐ Female ☐Unknown
Preferred Method of Contact: ☐ Email ☐ None

Please answer the following:

Is the recipient an Essential Frontline Worker (e.g., Police, Food Processing, Teacher, Healthcare Worker)?
☐No ☐Yes (if yes, employer's name is required):_____

Does the recipient reside or work in a long-term care facility?
☐No ☐Yes (If yes, facility's name is required): _____

Is the recipient part of a state or federal recognized tribal nation?
☐No ☐Yes (if yes, community name is required): _____

How many conditions known to increase risk of severe illness from COVID-19 does the recipient have?
☐None ☐One ☐Two or More (Conditions shown below):

- Asthma (moderate-to-severe)
- Neurologic conditions (e.g. dementia)
- Cancer
- Smoking
- Overweight (BMI > 25kg/m2, but < 30 kg/m2)
- Obesity (BMI of 30 kg/m2 or higher, but < 40 kg/m2)
- Cerebrovascular disease
- Chronic kidney disease
- Severe Obesity (BMI ≥ 40 kg/m2)
- Pregnancy
- Cystic Fibrosis
- COPD (chronic obstructive pulmonary disease)
- Sickle cell disease
- Hypertension or high blood pressure
- Pulmonary Fibrosis
- Immunocompromised
- Thalassemia
- Liver Disease
- Heart conditions (e.g. heart failure, coronary artery disease, cardiomyopathies)
- Type 1/Type 2 diabetes mellitus

For additional information on conditions: https://www.cdc.gov/coronavirus/2019-ncov/need-exxtra-precautions/people-with-medical-conditions.html

OFFICE USE ONLY

DISCLOSURE STATEMENT: Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include: shortness of breath, hoarseness of wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes or up to 48 hours after the vaccination. If the recipient is experiencing any of these symptoms, the recipient has been instructed to contact a healthcare provider immediately.

☐ • VERBAL CONSENT: The recipient or legal guardian has been provided the benefits and potential adverse reactions, and provides consent to receive the vaccine.

Vaccine Administration Worksheet

Recipient First Name: _____
Recipient Last Name: _____
Recipient Date of Birth: _____
Month Day Year

Administering Site Information
**Required Fields*

***Responsible Organization: Wilmington Health**

"Responsible Organization" is the name of the parent organization or health system that originated and is accountable for the content of the record. If an organization has several clinics or facilities, this would be the organization that represents all of the clinics/facilities.

*** Administration at Location: 1202 Medical Center Drive**

"Administration at Location" is the name of the physical clinic or facility that reported the vaccination, refusal, or missed appointment. In a small practice setting, this could be the same as the responsible organization.

Vaccine Administration Information:
**Required Fields*
***Administration Date:** **Month Day Year** ***Administration Time:** ☐ **AM** ☐ **PM**

***Vaccine Expiration Date:** **Month Date Year**

***Vaccine Barcode:** _____

***Vaccine Type (CVX):** _____ ***Vaccine Manufacturer (MVX): Pfizer**

***Vaccine Product (NDC):** _____ *** Vaccine Lot Number:** _____

***Available Vaccine Inventory:** _____

***Vaccine administered on behalf of (Clinician):**

***Vaccine Administering Site**
- ☐ Left Deltoid (LD)
- ☐ Right Deltoid (RD)
- ☐ Left Gluteus Medius (LG)
- ☐ Left Vastus Lateralis (LVL)
- ☐ Right Gluteus Medius (RG)
- ☐ Right Vastus Lateralis (RVL)

***Vaccine Route of Administration**
- ☐ Intramuscular (IM)
- ☐ Subcutaneous (SQ)

***Dose Number**
- ☐ First Dose
- ☐ Second Dose

Notes: