**COVID-19 Vaccination Record Card**

Please keep this record card, which includes medical information

about the vaccines you have received.

Last name First name

Date of birth Patient number *(medical record or IIS record number)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Vaccine** | **Product Name/Manufacturer Lot Number** | **Date** | **Healthcare Professional or Clinic Site** |
| 1st Dose COVID-19 |  | …./…./…… |  |
| 2nd Dose COVID-19 |  | …./…./…… |  |
| Other |  | …./…./…… |  |
| Other |  | …./…./…… |  |