COVID-19 VACCINATION RECORD CARD

Please keep this record card, which includes medical information about the vaccines you have received.

First Name _____ **Last Name** _____

Age / DOB ____/_____ **Insurrance No.** _____

Patient Number _____ **Gender** _____

Allergies _____

Vaccine	Product /Manufacturer Lot Number	Date	Healthcare Professional or Clinic Site
1st Dose **COVID-19**		__ / __ / __ M / D / Y	
2nd Dose **COVID-19**		__ / __ / __ M / D / Y	

Medical Director (or other authorized practitioner)

Name Signature _____

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