

# Immunization Information System Data Requirement Form

## COVID-19 Vaccine Administration



This form can be used in the rare instances when you are unable to access your jurisdiction's IIS due to technical issues or lack of internet access. When possible, information should always be captured electronically to avoid the least number of possible mistakes when transcribing.

However, this form may be printed to capture information manually. Vaccination providers are required to report vaccination administration information within 72 hours of administration. This information should be entered as soon you are able to access your jurisdiction's IIS or VAMS.

### Recipient Information

**ID** \_\_\_\_\_

**First Name** \_\_\_\_\_

**Middle Name (optional)** \_\_\_\_\_

**Last Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Sex**      Male                      Female                      Unknown

**Insurance Information (Optional)** \_\_\_\_\_

**Insurer** \_\_\_\_\_

**Primary insurance holder** \_\_\_\_\_

**Group/Individual ID number** \_\_\_\_\_

### Address

**Street 1** \_\_\_\_\_

**Street 2** \_\_\_\_\_

**City** \_\_\_\_\_

**County** \_\_\_\_\_

**State** \_\_\_\_\_

**Zip Code** \_\_\_\_\_

### Race *(select all that apply)*

<input type="checkbox"/>	American Indian/Alaskan Native
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Native Hawaiian or Pacific Islander
<input type="checkbox"/>	Black/African American

<input type="checkbox"/>	White
<input type="checkbox"/>	Other Race
<input type="checkbox"/>	Unknown
<input type="checkbox"/>	Unable to report

### Ethnicity *(select all that apply)*

<input type="checkbox"/>	Hispanic or Latino
<input type="checkbox"/>	Not Hispanic or Latino
<input type="checkbox"/>	Unknown
<input type="checkbox"/>	Unable to report

### Vaccine Information

Type	Product	Date Administered	Manufacturer	Lot Number	Expiration Date <i>mmddyyyy</i>	# Wasted

Administration Site	Administration Route
LA (Left arm)	IM
RA (Left arm)	C28161 (Intramuscular)
LE (lower extremity)      Left      Right	

<b>Dose Number</b>	_____	<b>Missed Appointment</b>	Y/N	<b>Comorbidity</b>	Y/N
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<b>Refused Vaccination</b>	Y/N	<b>If Yes, Reason</b>	_____
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<b>Vaccinator</b>	_____	<b>Received EUA Fact Sheet for Recipients</b>	Y/N
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