DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

Immunization Reporting Record

All Sections Required	
Practice Name(1) :	
Ordering Provider(2):	**Administering Provider**(3):
Patient Information	
Patient's Name (Last, First)(4):	**Sex** (6): ☐Male ☐Female
Patient's Address(5):	**DOB** (7): / / If under 18, parent/guardian must sign below
	Ethnicity (8): ☐Hispanic ☐Non-Hispanic
City, State Zip Code:	
RACE - Select all that apply(9) : ☐Caucasian/White ☐African American/Black ☐Am. Indian/Alaskan Native ☐Asian ☐Hawaiian or Other Pacific Islander ☐Other (Specify):	

Email:

Phone:

Do you have a physical disability? ☐ Yes ☐ No

COVID Vaccine Information: Please Print

Vaccine Date (MM/DD/YYY) / /

Manufacturer

Vaccine Expiration Date (MM/DD/YYY) / /

Lot Number

VIS/EUA Date (MM/DD/YYY) / /

Site (Check One): RD LD RA LA RT LT

Route (Check One): IM IT ID NS PO SC

Priority Group / Phase

Complete the next section and sign after you have talked with the clinician.

Vaccine to be administered : O First Vaccine Shot *OR* O Second Vaccine Shot

A filled in circle next to the vaccine (above) and my signature (below) means that I have been provided a copy of the appropriate Vaccine Information Statement and have read, or have had explained to me, information about the disease and the vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the statement received and I ask that the vaccine, as marked, be given.

Signature _____ Signer's Name _____

O Patient **If Patient Under 18:** O Parent O Guardian Print Clearly