*Keep in a safe place*

# RECORD OF COVID-19 IMMUNIZATION

*White Copy → Immunizer | Yellow → Client*

| Date | Name: Last, First | Personal Health Number | Birthdate (dd/mm/yyyy) |
|---|---|---|---|
| | | | |

**COMMON COVID-19 VACCINE SIDE EFFECTS CAN INCLUDE:**

☐ Pain at injection site, underarm lymph node swelling, tiredness, headaches, muscle pain, chills, joint pain, nausea, vomiting, fever.

☐ With any vaccine, there is a very rare chance of a severe allergic reaction. Get medical help right away if you experience trouble breathing, hives, or facial swelling.

For any serious or unexpected reactions, please inform your healthcare provider.

| Address | Phone # |
|---|---|
| | |

| Trade name | Dosage (mL) | Lot # | Site | Immunizer Signature |
|---|---|---|---|---|
| ☐ Pfizer ☐ Moderna ☐ AZ<br>☐ Janssen<br>☐ Other: _____ | | | L ☐ R ☐ | |

☐ **Informed consent**

Signature — For minor children and adults unable to self-consent — Print name and relationship to client

☐ **COVID-19 vaccine #_____ in_____weeks. Date_____**

Need more information?
Call 811 or visit www.healthlinkbc.ca

Vancouver CoastalHealth

VCH.VC.0238 | NOV.2021