

# COVID-19 Vaccination Record Card

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_

Dose	Vaccine	Manufacturer	Lot Number	Date	Healthcare Professional / Clinic Site
1 <sup>st</sup>					
2 <sup>nd</sup>					
3 <sup>rd</sup>					