Summary Report of COVID-19 Vaccination Event - Moderna 6 Months - 5 Years Old

First Event Date: _____ **Second Event Date:** _____

Type of event *(check one):* Testing: ☐ Vaccination: ☑ Combined: ☐

Name of the host organization: _____

Event setting *(check one)*:

POD ☐ Congregate setting ☐ Community ☐ Nursing home/LTC ☐ Other ☐ _____

Event Address: _____

COVID-19 VACCINATION

Type of vaccine *(check 1)*: Moderna Baby Vaccine ☐

	BABY 6 mo-5 years
# Dose 1	
# Dose 2	
# Additional Dose	
# Booster 1	
# Booster 2	

Number of RN's: ___ Admins: ___ NC:___ HC: ___

ML: ___ EMR: ___ PM: ___ SM: ___

Total Staff On-Site: _____ CIR Corrections Submitted: _____

Total number of persons vaccinated for COVID-19 6 months - 5 years old: _____

Number of clients/residents: _____

Number of staff: _____

Was EMS called to the site? Yes ☐ No ☐

Number of IRs completed: _____

Adverse reactions	**Check**	**Adverse reactions**	**Check**
Injection site pain, swelling, redness	☐	Nausea, dizziness, or weakness	☐
Tiredness	☐	Feeling unwell	☐
Headaches	☐	Swollen lymph node	☐
Muscle pain	☐	Difficulty breathing	☐
Chills	☐	Swelling of face and throat	☐
Joint pain	☐	Fast heartbeat	☐
Fever	☐	Rash	☐

I hereby certify that the data provided in the above report is accurate, true, and complete based upon my best knowledge and information available:

Signature of Affiliated Physicians' Event Coordinator: _____ Date: _____

Signature of DOHMH designee: _____ Date: _____