It's Your Best Shot!
CT WiZ
Connecticut
Immunization Information System

CT Immunization Information System
COVID-19 Vaccine Administration Record

Clinic Name/Address:

Patient Information

First Name _____ E-mail _____

Middle Name _____ Phone Number _____

Last Name _____

Date of Birth _____/_____/_____ Sex: Male Female Transgender Unknown
mm dd yyyy

Insurance Information *(optional)*

Primary Insurance Holder/Name _____

Insurer _____ Group/Individual ID Number _____

Address

Street 1 _____ County _____

Street 2 _____ State _____

City _____ Zip Code _____

Race *(select all that apply)*

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Unknown

Ethnicity *(select all that apply)*

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Vaccine Information

Type/Product	**Date Administered** mm/dd/yyyy	**Manufacturer**	**Lot Number**	**Expiration Date** mm/dd/yyyy

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

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

Scheduled 2nd Dose Appointment Date: _____/_____/_____ Clinic Name/Address: _____
mm dd yyyy

_____

_____