NEW YORK STATE | Department of Health

New York State Department of Health - Bureau of Immunization

COVID-19 Vaccine Screening and Consent Form for Children and Adults

Recipient Name (please print)		Preferred Name	
Address City State Zip			Email Address
Parent/Guardian/Surrogate (if applicable, please print)		Phone	Preferred Language
DOB	Current Gender ID **Key:** W – Woman/Girl TW – Transgender Woman/Girl M – Man/Boy Indicate ID Below: TM – Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming Q – Not Sure/Questioning NR – Chose not to Respond GNL - Gender not Listed (write-in) * Gender Pronouns: write-in by client's name		
Sex Assigned at Birth **Key:** M – Male Indicate Sex Below: F – Female I – Intersex NR – No Response		Marital Status **Key:** S – Single D – Divorced M – Married Indicate Status Below: W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner	
Ethnicity **Key:** DECL – Declined Indicate Ethnicity Below: HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown		Race **Key:** AIA – Native American or Alaskan ASN – Asian Indicate Race Below: BAA – African American or Black DECL – Declined NHP – Native Hawaiian or Pacific Islander WHT – White OTH – Other or Multiracial	
Medical Insurance Name		Medical Insurance ID#	Subscriber Name/DOB / Relation to Patient
Medical Insurance Address		Medical Insurance Group #	Medical Insurance Phone #
Clinic/Office Site Where Vaccine is Administered		Primary Care Physician Address/Phone Number	

Screening Questionnaire: The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given. It just means additional questions may be asked. If a question is not clear, please ask a healthcare provider to explain it.

1.	Are you feeling sick today?	□ Yes	□ No	□ Unknown
2.	In the last 10 days, have you had a COVID-19 test because you had symptoms or because you were exposed to COVID-19, and was the test positive or are you still awaiting your test results, OR in the last 10 days have you been told by a health care provider or health department to isolate at home due to COVID-19 infection, OR are you aware of an exposure to COVID-19 in the last 10 days?	□ Yes	□ No	□ Unknown
3.	How old will the person be on the day of vaccination? _____			
4.	Has the person to be vaccinated ever received a dose of any COVID-19 vaccine? • If yes, which product was administered? □ Pfizer-BioNTech □ Janssen (Johnson & Johnson) □ Another product □ Moderna □ Novavax _____ • How many doses of COVID-19 vaccine were previously administered? _____ • Did you bring the vaccination record card or other documentation?	□ Yes □ Yes	□ No □ No	□ Unknown
5.	Have you ever had an immediate allergic reaction (e.g., hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?	□ Yes	□ No	□ Unknown
6.	Are you moderately or severely immunocompromised due to one or more of the medical conditions or receipt of immunosuppressive medications or treatments listed below? 1) Active treatment for solid tumor, 2)hematologic malignancies, 3) Hematologic malignancies associated with poor responses to COVID-19 vaccines regardless of current treatment status (e.g., chronic lymphocytic leukemia, non-Hodgkin lymphoma, multiple myeloma, acute leukemia) 4) Receipt of solid-organ transplant and taking immunosuppressive therapy, 5) Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy), 6) Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome), 7) Advanced or untreated HIV infection, 8) Active treatment with high-dose corticosteroids (i.e., 20 mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory.	□ Yes	□ No	□ Unknown
7.	Are you pregnant or considering becoming pregnant?	□ Yes	□ No	□ Unknown
8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	□ Yes	□ No	□ Unknown
10.	Do you have a history of MIS-C or MIS-A (multisystem inflammatory syndrome in children or multisystem inflammatory syndrome in adults)?	□ Yes	□ No	□ Unknown
11.	Have you received an orthopoxvirus vaccine within the last 4 weeks (e.g., JYNNEOS or ACAM2000)?	□ Yes	□ No	□ Unknown

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. The Novavax COVID-19 vaccine is EUA authorized for those individuals 12 years and older. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine in individuals 12 years of age and older; and approved the Moderna COVID-19 vaccine in individuals 12 years of age and older. These vaccines continue to be available under an EUA for certain populations, including Pfizer-BioNTech COVID-19 vaccine for those individuals 6 months through 11 years old, and Moderna COVID-19 vaccine for individuals 6 months through 11 years old and for the administration of an additional dose in the populations set forth in the consent section below.

Emergency Use Instruction

Emergency Use Instructions (EUIs) are issued by the CDC to provide information about emergency use of FDA-approved medical products that may not be included in or differ in some way from the information provided in the FDA-approved labeling (package insert). The COVID-19 vaccine by Pfizer-BioNTech is an FDA-approved COVID-19 vaccine (brand name Comirnaty, mRNA) to prevent COVID-19 in persons 12 years of age and older. CDC is issuing EUI to provide information about use of this vaccine as an additional primary dose in certain immunocompromised persons (12 years of age and older) and a booster dose in certain adults (18 years of age and older) who received certain **non-FDA authorized or approved COVID-19 vaccine** (e.g., certain vaccines available outside of the United States or from clinical trial participation).

Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses to be considered fully vaccinated. Further, I understand that a booster dose of COVID- 19 vaccine is recommended at least 2 months following the completion of a COVID-19 vaccine primary series or a monovalent booster dose to increase my protection.

I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Recipient/Surrogate/Guardian Signature Date / Time Print Name Relationship to Patient (if other than recipient)

Telephonic Interpreter's ID # Date / Time

OR

Signature: Interpreter Date/ Time Print Interpreter's Name Relationship to Patient

Area Below to be Completed by Vaccinator. Which vaccine is the patient receiving today?					
Vaccine Name	**Administration**			**Manufacturer & Lot #**	**EUA Fact Sheet Date**
Pfizer/BioNTech	☐ 0.3 mL/3ug (Yellow Cap/Yellow Label) 	☐ 0.3 mL/10 ug (Blue Cap/Blue Label) 	☐ 0.3mL/30 ug (Gray Cap/Gray Label) 		
Moderna		☐ 0.25 mL/25 ug (Blue Cap/Green Label) 	☐ 0.5 mL/50 ug (Dark Blue Cap/Blue Label) 		
Novavax	☐ 0.5 mL 				
Accounting for any previous vaccine doses administered, which number dose is this? _____					
Injection Site	☐ Left Deltoid	☐ Right Deltoid	☐ Left Thigh	☐ Right Thigh	

☐ I have provided the patient (and/or parent, guardian, or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____ Date: _____

*** Use of this form is optional.** **Form adapted from the CDC screening checklist** **Updated October 13, 2023**