New York State Department of Health
Bureau of Immunization

COVID-19 Immunization Screening and Consent Form*

Recipient Name (please print)		Preferred Name	
DOB	Current Gender ID Indicate ID Below:	**Key:** W – Woman/Girl TW – Transgender Woman/Girl M – Man/Boy 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 Indicate Sex Below:	**Key:** M – Male F – Female I – Intersex NR – Chose not to Respond	Marital Status Indicate Status Below:	**Key:** S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner
Address City State Zip		Email Address	
Parent/Guardian/ Surrogate (if applicable, please print)		Phone	Preferred Language
Ethnicity Indicate Ethnicity Below:	**Ethnicity Key:** DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown	Race Indicate Race Below:	**Race Key:** AIA – Native American or Alaskan ASN – Asian BAA – African American or Black DECL – Declined NHP – Native Hawaiian or Pacific Islander WHT – White OTH – Other or Multiracial

Primary Insurance Name	Primary Insurance ID#	Subscriber Name/DOB	Subscriber Relation to Patient
Primary Insurance Address	Primary Insurance Group #	Primary Insurance Phone #	
Secondary Insurance Name	Secondary Insurance ID#	Subscriber Name/DOB	Subscriber Relation to Patient
Secondary Insurance Address	Secondary Insurance Group #	Secondary Insurance Phone #	
Clinic/Office Site Where Vaccine is Administered	Primary Care Physician Address/Phone Number		

Screening Questionnaire

1.	Are you feeling sick today?	□ Yes	□ No	
2.	In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate orquarantine at home due to COVID-19 infection or exposure?	□ Yes	□ No	□ Unknown
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?* Date: _____	□ Yes	□ No	□ Unknown
4.	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
5.	Are you pregnant or considering becoming pregnant?	□ Yes	□ No	□ Unknown

6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	□ Yes	□ No	□ Unknown
7.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	□ 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
9.	Are you 65 years old or older?	□ Yes	□ No	□ Unknown
10.	Are you 18 years old or older AND a resident of a long-term care facility?	□ Yes	□ No	□ Unknown
11.	Are you 50 through 64 years old AND have one or more of the following conditions (due to increased risk of moderate or severe illness or death from the virus that causes COVID-19): 1.) Cancer (current or in remission, including 9/11-related cancers); 2.) Chronic kidney disease; 3.) Pulmonary Disease, including but not limited to, COPD (chronic obstructive pulmonary disease), asthma (moderate-to-severe), pulmonary fibrosis, cystic fibrosis, and 9/11 related pulmonary diseases; 4.) Intellectual and Developmental Disabilities including Down Syndrome; 5.) Heart conditions, including but not limited to heart failure, coronary artery disease, cardiomyopathies, or hypertension (high blood pressure); 6.) Immunocompromised state (weakened immune system) including but not limited to solid organ transplant or from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, use of other immune weakening medicines, or other causes; 7.) Severe Obesity (BMI 40 kg/m2 or higher), Obesity (body mass index [BMI] of 30 kg/m2 or higher but < 40 kg/m2), Overweight (BMI of 25 kg/m2 or higher but < 30kg/m2); 8.) Pregnant; 9.) Sickle cell disease or Thalassemia; 10.) Type 1 or 2 diabetes mellitus; 11.) Cerebrovascular disease (affects blood vessels and blood supply to the brain); 12.) Neurologic conditions including but not limited to Alzheimer's Disease or dementia; 13.) Liver disease; 14.) Current or former smoker; 15.) Substance use disorder	□ Yes	□ No	□ Unknown
12.	Are you 18 through 49 years old AND have one or more of the underlying medical conditions listed above, and are seeking a booster because the benefits outweigh the risks?	□ Yes	□ No	□ Unknown
13.	Are you 18 through 64 years old AND are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting?	□ Yes	□ No	□ Unknown
14.	Have you received 2 doses of the Pfizer vaccine, the second dose being at least 6 months ago?	□ Yes	□ No	Date of 2nd dose: _____ (if applicable
15.	Have you received a previous dose of Moderna or Janssen COVID-19 vaccine?	□ Yes	□ No	□Unknown
16.	Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm/BIBP)?	□ 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. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 12 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

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 third dose of my vaccine ("booster") may be recommended for me to receive at least 6 months following the second dose of Pfizer-BioNTech COVID-19 vaccine if I am a member of a certain population (e.g., 65 years or older, a resident of a long term care facility, 50-64 years with an underlying medical condition, 18-49 years with an underlying medical condition based on individual benefits and risks, 18-64 years and at an increased risk for COVID-19 exposure and transmission because of occupational or institutional setting based on individual benefits and risks) to increase my protection.

I have had a chance to ask questions which were answeredto 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) recipient	Date / Time	Print Name	Relationship to Patient (if other than recipient)

Telephonic Interpreter's ID # **OR**	Date / Time

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

Area Below to be Completed by Vaccinator					
Which vaccine is the patient receiving today?					
Vaccine Name	**Administration**			**EUA Fact Sheet Date**	**Manufacturer & Lot #**
Pfizer/BioNTech	□ First Dose	□ Second Dose	□ Third Dose		
Moderna	□ First Dose	□ Second Dose			
Astra-Zeneca	□ First Dose	□ Second Dose			
Janssen	□ Single Dose				
Administration Site	□ Left Deltoid	□ Right Deltoid	□ Left Thigh	□ Right Thigh	
Dosage	□ 0.5 ml	□ 0.3 ml			

□ 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: _____

*** Use of this form is optional.** **Updated September 29, 2021**