New York State Department of Health
Bureau of Immunization

# COVID-19 Vaccine Screening and Consent Form

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|---|---|---|---|
| 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<br>Indicate ID Below: TM – Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming<br>☐ Q – Not Sure/Questioning NR – Chose not to Respond<br>GNL - Gender not Listed (write-in) * Gender Pronouns: write-in by client's name | | |
| Sex Assigned at Birth **Key:**<br>Indicate Sex Below: M – Male F – Female<br>☐ I – Intersex<br>NR – Chose not to Respond | | Marital Status **Key:** S – Single D – Divorced M – Married<br>Indicate Status Below: W – Widowed V – Civil Union<br>☐ U – Unknown SEPARATED – Legally Separated<br>PARTNER – Life Partner | |
| Ethnicity **Key:** DECL – Declined<br>Indicate Ethnicity Below: HIS – Hispanic Origin<br>☐ NHL – Non-Hispanic Origin<br>UNK – Unknown | | Race **Key:** AIA – Native American or Alaskan ASN – Asian<br>Indicate Race Below: BAA – African American or Black DECL – Declined<br>☐ NHP – Native Hawaiian or Pacific Islander<br>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**

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| 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 and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine 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 |

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| 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. | Have you had Guillain-Barre Syndrome after receipt of the Janssen vaccine? | □ Yes | □ No | □ Unknown |
| 11. | 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 |
| 12.* | Are you 12 years of age or older and have you received a complete COVID-19 vaccine primary series (e.g., 2 doses of Moderna, Pfizer, or Novavax vaccine, or 1 dose of Janssen vaccine) or any booster dose at least 2 months ago? | □ Yes | □ No | _____ Date of last dose: (if applicable) |
| 13.** | If you had a previous dose of Janssen (Johnson & Johnson), did you develop thrombosis with thrombocytopenia syndrome (TTS)? | □ Yes | □ No | □ Unknown |
| 14.[1] | Have you received a previous dose of a non-FDA authorized or approved COVID-19 vaccine authorized by the WHO[1] but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm/BIBP, COVAXIN, Nuvaxovid, COVOVAX, or CanSino Biologics – Convidecia)? | □ Yes | □ No | □ Unknown |

***Question #12 pertain to monovalent/bivalent booster dose eligibility for Pfizer, Moderna, Novavax or Janssen.**

****Question #13 pertains to booster dose eligibility for Janssen.**

[1] As set forth in the CDC's Emergency Use Instructions (EUI) , a non-FDA authorized or approved COVID-19 vaccine such as those vaccines "listed for emergency use by the World Health Organization, or is included in CDC's Technical Instructions for Implementing Presidential Proclamation Advancing Safe Resumption of Global Travel During the COVID-19 Pandemic and CDC's Order, or that is a non-placebo part of a clinical trial within or outside the United States that is a WHO-EUL COVID-19 vaccine or a vaccine that is not listed for emergency use by WHO but for which a U.S. data and safety monitoring board or equivalent has independently confirmed efficacy in the United States (hereinafter '"non-FDA authorized or approved COVID-19 vaccines').

**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 Janssen (Johnson & Johnson) COVID-19 vaccine is EUA authorized for those individuals 18 years old and older. 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 as a two-dose series in individuals 16 years of age and older; and approved the Moderna COVID-19 vaccine as a two-dose series in individuals 18 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 15 years old, and Moderna COVID-19 vaccine for individuals 6 months through 17 years old and for the administration of a third 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 first dose of Janssen vaccine (if I am age 18 or older), or at least 5 months following the second dose of Pfizer-BioNTech (if I am age 5 -11 years old) or at least 2 months following my most recent vaccine if I am 12 years old or older (Pfizer-BioNTech or Moderna COVID-19 vaccine) 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 and 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 | □ First Dose | □ Second Dose | □ Bivalent Booster (≥ 12 years old) | | | |
| Moderna | □ First Dose | □ Second Dose | □ Bivalent Booster (≥ 18 years old) | | | |
| Novavax | □ First Dose | □ Second Dose | □ Bivalent mRNA Booster (≥ 18 years old) | | | |
| Janssen | □ Single Dose | □ Additional Dose | □ Bivalent mRNA Booster (≥ 18 years old) | | | |
| Administration Site | □ Left Deltoid | □ Right Deltoid | □ Left Thigh | □ Right Thigh | | |
| Dosage | □ 0.5 ml | □ 0.3 ml | □ 0.25 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 13, 2022**