



**Department of Health**

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: <input type="text"/>	<b>Key:</b> 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: <input type="text"/>	<b>Key:</b> M – Male F – Female I – Intersex NR – Chose not to Respond	Marital Status Indicate Status Below: <input type="text"/>	<b>Key:</b> S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner
Address		City	State Zip
Parent/Guardian/ Surrogate (if applicable, please print)		Phone	Preferred Language
Ethnicity Indicate Ethnicity Below: <input type="text"/>	<b>Ethnicity Key:</b> DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK - Unknown	Race Indicate Race Below: <input type="text"/>	<b>Race Key:</b> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 or quarantine at home due to COVID-19 infection or exposure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? <i>If yes, when did you receive the last dose? Date: _____</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
5.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot? <i>If yes, how long ago was your most recent vaccine? Date: _____</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
6.	Are you pregnant or considering becoming pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

7.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
8.	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
9.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
10.	Have you received a previous dose of the COVID-19 vaccine? If yes, which vaccine?	<input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer		<input type="checkbox"/> No Date: _____ (if applicable)

### 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.

### 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 of this vaccine in order for it to be effective. 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) recipient	Date / Time	Print Name	Relationship to Patient (if other than recipient)
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Telephonic Interpreter's ID # OR	Date / Time
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Signature: Interpreter	Date/ Time	Print: Interpreter's Name and Relationship to Patient
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### Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today?			
Vaccine Name	Administration		Manufacturer & Lot Number
Pfizer/ BioNTech	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	
Moderna	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	
Astra-Zeneca	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	
Janssen	<input type="checkbox"/> 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: \_\_\_\_\_