NEW YORK STATE | Department of Health

trillium HEALTH

COVID-19 Immunization Screening and Consent Form (please print)

Recipient Name:

Preferred Name:

Gender Pronouns:

Date of Birth:

Email Address:

Preferred Language:

Address:

City / State / Zip:

Phone Number:

Parent/Guardian/Surrogate
if under 18 years old

Sex Assigned at Birth:	**Key:** M - Male W - Female I - Intersex NR - Chose not to Respond

Current Gender ID:	**Key:** W - Woman/Girl TW - Transgender Woman/Girl NB - Non Binary Person Q - Questioning/Not Sure	M - Man/Boy TM - Transgender Man/Boy GNC - Gender Non-Conforming NR - Chose not to Respond GNL - Gender not Listed (write in)

Ethnicity:	**Key:** DECL - Declined HIS - Hispanic NHL - Non-Hispanic UNK - Unknown

Race:	**Key:** AIA - Native American or Alaskan BAA - African American or Black NHP - Native Hawaiian or Pacific Islander OTH - Other or Multiracial	WHT - White ASN - Asian DECL -Declined

Primary Insurance Name:

Primary Insurance ID #:

Uninsured Social Security #:

Are you: *(check all that apply)* ☐ Living in Public Housing ☐ A migrant worker ☐ Homeless

Screening Questionnaire

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.*	Are you moderately or severely immunocompromised due to one or more of the medical conditions or receipt of immunosuppressive medications or treatments, as listed below? · HIV infection · Active treatment for solid tumor and hematologic malignancies · Receipt of solid-organ transplant and taking immunosuppressive therapy · Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy) · Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome) · Active treatment with high-dose corticosteroids (i.e., 20mg 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.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	☐ Yes	☐ No	☐ Unknown
8.	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.	Have you received 2 doses of the Pfizer or Moderna COVID-19 vaccine? *Date of second dose, if applicable:* _____	☐ Yes	☐ No	☐ Unknown
10.	Have you received a previous dose of the Janssen COVID-19 vaccine? *Date of first dose, if applicable:* _____	☐ Yes	☐ No	☐ Unknown
11.	If you had a previous dose of Janssen (Johnson & Johnson), did you develop thrombosis with thrombocytopenia syndrome (TTS)?	☐ Yes	☐ No	☐ Unknown
12.	Has it been at least 2 months since you last received a booster dose or completed the primary series of a COVID-19 vaccine?	☐ Yes	☐ No	☐ Unknown
13.	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

**Question 6 pertains to additional dose eligibility*

please continue to next page

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; 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 to 15 years old, and Moderna COVID-19 vaccine for individuals 6 months to 17 years old 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.

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*

Area Below to be Completed by Vaccinator

Vaccine Name	Administration	EUA Fact Sheet Date	Manufacturer & Lot #
Pfizer / BioNTech	☐ First Dose ☐ Second Dose ☐ Additional Dose ☐ Booster Dose		
Moderna	☐ First Dose ☐ Second Dose ☐ Additional Dose ☐ Booster Dose		
Janssen	☐ First Dose ☐ Booster Dose		
Administration Site	☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh		
Dosage	☐ 0.5 ml ☐ 0.3 ml ☐ 0.25 ml ☐ 0.2 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.

Signature, Vaccinator

PLACE Rx LABEL HERE