New York State Department of Health
Bureau of Immunization

COVID-19 Immunization Screening and Consent Form:* Children and Adolescents Ages 5 – 11 years old

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 between the ages of 5 and 11 years old?	☐ Yes	☐ No	
2.	Are you 12 years old or older?	☐ Yes	☐ No	
3.	Are you feeling sick today?	☐ Yes	☐ No	
4.	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
5.	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
6.	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

7.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	□ Yes	□ No	□ 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?	□ Yes	□ No	□ Unknown
9.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
10.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	□ Yes	□ No	□ Unknown
11.	Have you received a previous dose of the Pfizer, Moderna, or Janssen vaccine?	□ Yes	□ No	
12.	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, COVAXIN)?	□ 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 5 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 booster dose of COVID-19 vaccine may be recommended at least 2 months following the first dose of Janssen vaccine or at least 6 months following the second dose of Pfizer-BioNTech or Moderna COVID-19 vaccine if I am a member of a certain population (e.g., 65 years or older, 18 years old or older and a resident of a long term care facility, 50-64 years with an underlying medical condition, 18-49 years old with an underlying medical condition based on individual benefits and risks, 18-64 years old and at an increased risk for COVID-19 exposure and transmission because of working or living in a high-risk setting and based on individual benefits and risks) 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) 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			
Moderna	NA	NA			
Janssen	NA				

Administration Site	□ Left Deltoid	□ Right Deltoid	□ Left Thigh	□ Right Thigh
Dosage		□ 0.3 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.

Vaccinator Signature: _____

*** Use of this form is optional.** **Updated November 8, 2021**