



Department of Health

New York State Department of Health Bureau of Immunization

COVID-19 Immunization Screening and Consent Form\*: Children and Adolescents Ages 5 – 12 years old

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 between the ages of 5 and 11 years old?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2.	Are you 12 years old or older?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3.	Are you feeling sick today?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 or quarantine at home due to COVID-19 infection or exposure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<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.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
11.	Have you received a previous dose of the Pfizer, Moderna, or Janssen vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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)      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		EUA Fact Sheet Date	Manufacturer & Lot #
	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose		
Pfizer/BioNTech	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose		
Moderna	NA	NA		
Janssen	NA			
Administration Site	<input type="checkbox"/> Left Deltoid	<input type="checkbox"/> Right Deltoid	<input type="checkbox"/> Left Thigh	<input type="checkbox"/> Right Thigh
Dosage		<input type="checkbox"/> 0.3 ml	<input type="checkbox"/> 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 4, 2021**