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:	**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 SNL – Sexual Orientation not Listed (write-in)	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 feeling sick today?	□ Yes	□ 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, exposure or travel?	□ 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.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot? *If yes, how long ago was your most recent vaccine?* Date: _____	□ Yes	□ No	□ Unknown
6.	Are you pregnant or considering becoming pregnant?	□ Yes	□ No	□ Unknown

7.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease 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 or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
10.	Have you received a previous dose of the COVID-19 vaccine? If yes, which vaccine? □ Moderna □ Pfizer		□ 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)
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 Number
Pfizer/ BioNTech	□ First Dose	□ Second Dose		
Moderna	□ First Dose	□ Second Dose		
Astra-Zeneca	□ First Dose	□ Second Dose		
Janssen	□ 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: _____

Use of this form is optional. In the ongoing effort to address health disparities it is essential that all demographic information is collected at the time of COVID-19 vaccination including sex/gender identity and race/ethnicity.* **Updated January 20, 2021

WHITNEY YOUNG HEALTH

HEALTHCARE DESIGNED AROUND

COVID VACCINE REGISTRATION FORM

Please circle Yes or No for the following questions. Are you:

Y N An agricultural worker

Y N Homeless

Y N Living in public housing

Sexual Orientation:

_____ Lesbian, gay or homosexual

_____ Straight or heterosexual

_____ Bisexual

_____ Something else, please describe:

_____ Don't know

_____ Choose not to disclose

By signing this form, you give consent to Whitney M. Young, Jr. Health Services (WYH), staff physicians, allied health professionals, nurses, and technicians involved in care of the patient above to administer COVID 19 vaccination services and to perform such treatment or procedures that are necessary in the normal course of providing these services.

_____ _____

Patient Name | Patient Date of Birth

_____ _____

Legal Guardian Name (if applicable) | Relationship to Patient

_____ _____

Signature of Patient or Legal Guardian | Signature Date

_____ _____ _____

Witness Name | Witness Signature | Witness Date