NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

# COVID-19 Immunization Screening and Consent Form*

| | | | | |
|---|---|---|---|---|
| Recipient Name (please print) | | | Preferred Name | |
| DOB | Legal Gender | Gender ID | Marital Status | **Marital Status Key:**<br>S – Single D – Divorced M – Married<br>W – Widowed V – Civil Union U – Unknown<br>SEPARATED – Legally Separated PARTNER – Life Partner |
| Address City State Zip | | | | Email Address |
| Parent/Guardian/ Surrogate (if applicable, please print) | | | Phone | Preferred Language |
| Ethnicity **Ethnicity Key:**<br>DECL – Declined HIS – Hispanic Origin<br>NHL – Non-Hispanic Origin<br>UNK - Unknown | | | Race **Race Key:**<br>AIA – Native American or Alaskan ASN – Asian<br>BAA – African American or Black DECL – Declined<br>NHP – Native Hawaiian or Pacific Islander<br>WHT – White OTH – Other or Multiracial | |
| 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 or been told by a healthcare 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 for COVID-19 in the past 90 days (3 months)?<br>*If yes, when did you receive the last dose?* | □ Yes | □ No | □ Unknown |
| 4. | Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot? | □ Yes | □ No | □ Unknown |
| 5. | Have you had any vaccines in the past 14 days (2 weeks) including flu shot?<br>*If yes, how long ago was your most recent vaccine?* | □ 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 |

**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 completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

December 2020

**Consent**

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity 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 insurance plan, Medicare, Medicaid 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 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 □ 0.3ml

□ I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable)

□ I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

Vaccinator Signature: _____

*** Use of this form is optional.**

December 2020

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

# Information for Healthcare Professionals about the Screening Checklist for the COVID-19 Vaccine*

**NOTE**: For summary information on contraindications an precautions to vaccines, go to the ACIP's General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html

* This form is current as of December 13, 2020. Please consult ACIP, FDA and relevant manufacturer's websites for the most cu rrent clinical updates including, but not limited to: ACIP at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html and FDA at https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine.

1. **Are you feeling sick today?**

   If yes, refer to the vaccination site healthcare provider for assessment of current health status. If patient is feeling moderately or severely ill, do not vaccinate at this time and ask the patient to return when symptoms improve.

2. **In the last 10 days have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure? Are you on quarantine because of travel requirements?**

   If yes, advise patient to return to isolation/quarantine, and reschedule for after isolation or quarantine ends.

   If patient was diagnosed with COVID-19 greater than 10 days ago and has been asymptomatic for 24 hours or more, patient may be vaccinated.

   If the patient has had a test in the last 10 days, ask the result. If positive send them home, if negative they can proceed to vaccination. If the result is unsure or unknown advise the patient to return once a negative test has been confirmed or 10 days have passed since a positive test.

3. **Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? If yes, when did you receive the last dose?**

   If yes, reschedule at least 90 days after last dose of antibody therapy.

4. **Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?**

   If yes, then refer to the vaccination site healthcare provider for assessment of allergic reaction.

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?**

   If yes, then reschedule at least 14 days after the most recent vaccine.

6. **Are you pregnant or considering becoming pregnant?**

   If yes, ask the patient to consider having a discussion with her/their provider or a healthcare provider at site for counseling on the risks and benefits of COVID-19 vaccine during pregnancy.

   Patient may be vaccinated if they choose.

7. **Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?**

   If yes, refer to the vaccination site healthcare provider to discuss what is known and not yet known about COVID-19 vaccine for immunocompromised people.

   You can tell the patient that If they are immunocompromised or are on a medicine that affects their immune system, they may have a less strong immune response to the vaccine but may still get vaccinated. They should continue to follow current guidance to protect themselves against COVID-19.

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 recently?**

   If yes, refer to healthcare provider to discuss what is known and not yet known about COVID-19 vaccine for immunosuppressed people.

   You can tell the patient that if they are immunocompromised or are on a medicine that affects their immune system, they may have a less strong immune response to the vaccine but may still get vaccinated. They should continue to follow current guidance to protect themselves against COVID-19.

*** Anyone answering "Unknown" to any screening question should be referred to the medical director or responsible healthcare provider at the POD or clinic to further assess their answer to that question. (E.g., the person might not have understood the question and the healthcare provider could explain it further).**