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Onondaga County Health Department
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Screening and Consent for Third Dose of Pfizer/Moderna COVID-19 Vaccine

Name *(please print):* _____ **DOB:** _____ **Preferred Language:** _____

Current Gender ID: ☐ Woman/Girl ☐ Transgender Woman/Girl ☐ Man/Boy ☐ Transgender Man/Boy ☐ Non-Binary
☐ Gender Non-Conforming ☐ Not Sure/Questioning ☐ Choose Not to Answer
☐ Gender Not Listed *(write in):* _____ Gender Pronouns *(optional):* _____

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex ☐ Choose Not to Answer

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Civil Union ☐ Legally Separated ☐ Life Partner ☐ Choose Not to Answer

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Email Address: _____ **Phone:** _____

Parent/Guardian/Surrogate Name *(if applicable):* _____

Race: ☐ Native American or Alaskan ☐ African American or Black ☐ Native Hawaiian or Pacific Islander
☐ Asian ☐ White ☐ Other or Multiracial ☐ Choose Not to Answer

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Unknown ☐ Choose Not to Answer

Primary Insurance: _____ ID#: _____ Group #: _____

Insurance Address: _____ Insurance Phone Number: _____

Subscriber's Name: _____ DOB: _____ Relation to Patient: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Insurance Address: _____ Insurance Phone Number: _____

Subscriber's Name: _____ DOB: _____ Relation to Patient: _____

Primary Care Physician: _____ Phone: _____

Clinic/Office Where Vaccine is Being Administered: _____

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 at home due to COVID-19 infection?	☐ Yes ☐ No ☐ Unknown
3.	In the last 10 days, have been told by a healthcare provider or health department to quarantine at home due to COVID-19 exposure or travel?	☐ Yes ☐ No ☐ Unknown
4.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? **If yes,** when was your **last** dose? Date: _____	☐ Yes ☐ No ☐ Unknown
5.	Have you ever had an immediate allergic reaction, such as hives, facial swelling, difficulty breathing or anaphylaxis, to any vaccine or shot or to any component of the COVID-19 vaccine, such as polyethylene glycol (PEG) or polysorbate?	☐ Yes ☐ No ☐ Unknown
6.	Have you had any vaccines in the past 14 days (2 weeks) including a flu shot? **If yes,** how long ago was your **most recent** vaccine? Date: _____	☐ Yes ☐ No ☐ Unknown
7.	Are you pregnant or considering becoming pregnant?	☐ Yes ☐ No ☐ Unknown
8.	Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No ☐ Unknown
9.	Have you received two previous doses of either Pfizer or Moderna COVID-19 vaccine? **If yes,** date of second dose: _____	☐ Yes ☐ No ☐ Unknown
10.	Are you moderately to severely immunocompromised and have one of the following conditions?	☐ Yes ☐ No ☐ Unknown

- Receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system
- Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response

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 have received two doses of Pfizer or Moderna vaccine, and understand that I will need a third dose of the vaccine in order for it to be effective due to my immunocompromised state. 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 vaccine 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 Signature (or parent/surrogate/guardian)	*Print Name*	*Relationship to Patient (if not recipient)*	*Date*

If an interpreter was used to complete this form:

_____ **OR**	_____	_____	_____
Telephonic Interpreter's ID #	*In-Person Interpreter (Signature)*	*Print Name*	*Date*

Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today?

Vaccine Name	*Administration*	*EUA Fact Sheet Date*	*Lot Number*
Pfizer/BioNTech	☐ Third Dose		
Moderna	☐ Third Dose		

Administration Site: ☐ Left Deltoid ☐ Right Deltoid

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