New York State Department of Health
Bureau of Immunization

COVID-19 Immunization Screening and Consent Form: *Children and Adolescents Ages 6 Months–11 Years Old

Recipient Name (please print)		Preferred Name	
Address City State Zip			Email Address
Parent/Guardian/ Surrogate (if applicable, please print)		Phone	Preferred Language
DOB	Current Gender ID **Key:** W – Woman/Girl TW – Transgender Woman/Girl M – Man/Boy Indicate ID Below: 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 **Key:** Indicate Sex Below: M – Male F – Female I – Intersex NR – Chose not to Respond		Marital Status **Key:** S – Single D – Divorced M – Married Indicate Status Below: W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner	
Ethnicity **Key:** DECL – Declined Indicate Ethnicity Below: HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown		Race **Key:** AIA – Native American or Alaskan ASN – Asian Indicate Race Below: 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 6 months and 11 years old?	□ Yes	□ No	
2.	Are you feeling sick today?	□ Yes	□ No	
3.	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 toisolate or quarantine at home due to COVID-19 infection or exposure?	□ Yes	□ No	□ Unknown
4.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90days (3 months)? *If yes, when did you receive the last dose? Date:* _____	□ Yes	□ No	□ Unknown
5.	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 asevere allergic reaction (anaphylaxis) to anything?	□ Yes	□ No	□ Unknown
6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	□ Yes	□ No	□ Unknown
7.	Do you take any medications that affect your immune system, such as cortisone, prednisone orother steroids, anticancer drugs, or have you had any radiation treatments?	□ Yes	□ No	□ Unknown
8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis(inflammation of the lining around the heart)?	□ Yes	□ No	□ Unknown
10.	Do you have a history of MIS-C (Multisystem Inflammatory Syndrome in Children)?	□ Yes	□ No	□ Unknown
11.	Have you received a previous dose of the Pfizer, Moderna, or Janssen vaccine?	□ Yes	□ No	
12.*	Have you received 2 doses of the Pfizer or Moderna vaccine with the second dose being at least 2 months ago?	□ Yes	□ No	
13.	Have you received a previous dose of a COVID-19 vaccine recognized by the WHO but NOT by theFDA (AstraZeneca - VAXZEVRIA, Sinovac - CORONAVAC, Serum Institute of India - COVISHIELD, Sinopharm / BIBP, Covaxin, Serum Institute of India – NUVAXOVID, or CanSino Biologics - Convidecia)?	□ Yes	□ No	□ Unknown

***Question 12 pertains to booster dose eligibility.**

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 12 years of age and older; and approved the Moderna COVID-19 vaccine as a two-dose series in individuals 18 years of age and older. These vaccines continue to be available under an EUA for certain populations, including Pfizer-BioNTech COVID-19 vaccine for those individuals 6 months to 11 years old, and Moderna COVID-19 vaccine for individuals 6 months to 17 years old 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 is recommended for those 5 years of age and older at least 2 months following the completion of a COVID-19 vaccine primary series or a monovalent booster dose 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 authorizedto 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**				**Manufacturer & Lot #**	**EUA Fact Sheet Date**
Pfizer/BioNTech	□ First Dose	□ Second Dose	□ Bivalent Booster (5 years – 11 years)			
Moderna	□ First Dose	□ Second Dose	□ Bivalent Booster (6 years – 11 years)			
Administration Site	□ Left Deltoid	□ Right Deltoid	□ Left Thigh	□ Right Thigh		
Dosage	□ 0.2 ml	□ 0.25 ml	□ 0.3 ml	□ 0.5 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 October 18, 2022**