New York State Department of Health
Bureau of Immunization

COVID-19 Immunization Screening and Consent Form

Additional Dose for Moderately to Severely Immunocompromised

Updated: November 21, 2021

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		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.	Will you be under the age of 12 years old for the Pfizer vaccine, or under 18 years old for the Moderna vaccine, on the day of your appointment?	☐ 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 to isolate orquarantine 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 90 days (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 a severe allergic reaction (anaphylaxis) to anything?	☐ Yes	☐ No	☐ Unknown
6.	Are you pregnant or considering becoming pregnant?	☐ Yes	☐ No	☐ Unknown

7.	Are you moderately or severely immunocompromised due to one or more of the medical conditions or receipt of immunosuppressive medications or treatments listed below? 1) Active treatment for solid tumor and hematologic malignancies, 2) Receipt of solid-organ transplant and taking immunosuppressive therapy, 3) Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy), 4) Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome), 5) Advanced or untreated HIV infection, 6) Active treatment with high-dose corticosteroids (i.e., 8805;20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory	□ 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.	Have you received 2 previous doses of the Pfizer or Moderna COVID-19 vaccine, and was your last dose at least 28 days ago?	□ Yes	□ No	Date: _____ (if applicable)
11.	Have you received a previous dose of the Janssen/Johnson & Johnson COVID-19 vaccine?	□ Yes	□ No	
12.	Have you received a previous dose or doses of a non-FDA authorized or approved COVID-19 vaccine (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm/BIBP, COVAXIN)?	□ Yes	□ No	Date(s): _____ (if applicable)

[1] As set forth in CDC's Emergency Use Instruction (EUI), "a non-FDA authorized or approved COVID-19 vaccine includes such vaccines "listed for emergency use by the World Health Organization, or is included in CDC's Technical Instructions for Implementing Presidential Proclamation Advancing Safe Resumption of Global Travel During the COVID-19 Pandemic and CDC's Order, or that is a non-placebo part of a clinical trial within or outside the United States that is a WHO-EUL COVID-19 vaccine or a vaccine that is not listed for emergency use by WHO but for which a U.S. data and safety monitoring board or equivalent has independently confirmed efficacy in the United States (hereinafter 'non-FDA authorized or approved COVID-19 vaccines')."

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.

Emergency Use Instruction

Emergency Use Instructions (EUIs) are issued by the CDC to provide information about emergency use of FDA-approved medical products that may not be included in or differ in some way from the information provided in the FDA-approved labeling (package insert). The COVID-19 vaccine by Pfizer-BioNTech is an FDA-approved COVID-19 vaccine (brand name Comirnaty, mRNA) to prevent COVID-19 in persons 16 years of age and older. CDC is issuing EUI to provide information about use of this vaccine as an additional primary dose in certain immunocompromised persons (12 years of age and older) and a booster dose in certain adults (18 years of age and older) who received certain **non-FDA authorized or approved COVID-19 vaccine** (e.g., certain vaccines available outside of the United States or from clinical trial participation).

Consent

I hereby certify under penalty of law that I am of an age and, if applicable, immunocompromised (e.g., moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments) as authorized by an EUA or in accordance with an EUI, as applicable, to receive this vaccine, or, the person for whom I am legally authorized to make health care decisions is of an age and, if applicable, immunocompromised as authorized by an EUA or in accordance with an EUI, as applicable, to receive this vaccine. 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 providesurrogate 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	□ Third Dose		
Moderna	□ First Dose	□ Second Dose	□ Third Dose		

Administration Site □ Left Deltoid □ Right Deltoid □ Left Thigh □ Right Thigh

Dosage □ 0.5 ml □ 0.3 ml □ 0.25 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 21, 2021**