



Recipient Name (please print)	DOB
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**Screening Questionnaire**

1.	Are you feeling sick today?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? <i>If yes, when did you receive the last dose? Date: _____</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
4.	Have you ever had an immediate allergic reaction (e.g., hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injections, or shot or to any component of the COVID-19 vaccines, or a severe allergic reaction (anaphylaxis) to anything?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
5.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot+? <i>If yes, how long ago was your most recent vaccine? Date: _____</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
6.	Are you pregnant, considering becoming pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
7.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
9.	Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
10.	Have you received a previous dose of the COVID-19 vaccine? If yes, which vaccine? <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Janssen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**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.

**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.

I acknowledge and consent that information regarding my identity and all my immunizations will be released to the New York Citywide Immunization Registry (CIR).

Parent/Guardian (Signature)	Date / Time	Print Name	Relationship to patient
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Telephonic Interpreter’s ID #	Date / Time
<b>OR</b>	

Signature: Interpreter	Date/ Time	Print: Interpreter’s Name and Relationship to Patient
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Last, First Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**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	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose		
Moderna	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose		
Astra-Zeneca	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose		
Janssen	<input type="checkbox"/> Single Dose			

Administration Site:     Left Deltoid     Right Deltoid

Dosage:                     0.3 mL                     0.5 mL

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: \_\_\_\_\_