**COVID-19 Immunization Screening and Consent Form**

**Additional / Booster Dose (3rd) for Established Patient (Adult)**

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| Recipient Name (please print) | | DOB | | | | | | | |
| **Screening Questionnaire** | | | | | | | | | |
| 1. | Are you feeling sick today? | | | | Yes | | | No | |
| 2. | 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 or quarantine at home due to COVID-19 infection or exposure? | | | | Yes | No | | | Unknown |
| 3. | 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 |
| 4. | Have you ever had an immediate allergic reaction 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 |
| 5. | Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner? | | | | Yes | No | | | Unknown |
| 6. | Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)? | | | | Yes | No | | | Unknown |
| 7. | Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA? (E.g., AstraZeneca - VAXZEVRIA, Sinovac - CORONAVAC, Serum Institute of India - COVISHIELD, Sinopharm) | | | | Yes | No | | | Unknown |
| 8. | Have you received a previous dose of the COVID-19 vaccine?  Yes  No  If yes, which vaccine? | | Moderna | Pfizer | | | Janssen | | |
| 9. | Have you completed a primary vaccine series? (Moderna/Pfizer: 2-doses series; Janssen: 1-dose series) | | | | Yes | | | No | |
| 10. | I have reviewed all the eligibility groups for the additional/booster dose of Moderna/Pfizer COVID-19 vaccine and attest that I am eligible based on the criteria listed. | | | | Yes | | | No | |
| **Please answer Q11a if you come for Additional Dose, answer Q11b if you come for Booster Dose** | | | | | | | | | |
| 11a | For Additional Dose:  Have you received 2 doses of the Pfizer/Moderna vaccine, the second dose being at least 28 days? | | | | Yes | | | No | |
| 11b | For Booster Dose:  Have you received 2 doses of the Pfizer/Moderna vaccine, the second dose being at least 6 months ago? | | | | Yes | | | 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 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 12 through 15 years of age 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 third dose of my vaccine (“booster”) may be recommended for me to receive at least 6 months following the second dose of Pfizer-BioNTech COVID-19 vaccine if I am a member of a certain population (e.g., 65 years or older, a resident of a long term care facility, 50-64 years with an underlying medical condition, 18-49 years with an underlying medical condition based on individual benefits and risks, 18-64 years and at an increased risk for COVID-19 exposure and transmission because of occupational or institutional setting based on individual benefits and risks) 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 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 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.

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

Recipient/Surrogate/Guardian (Signature) Date / Time Print Name Relationship to patient, if other than recipient

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 | First Dose | Second Dose | | Third Dose |  |  |
| Moderna | First Dose | Second Dose | | Third Dose |  |  |
| Astra-Zeneca | First Dose | | Second Dose | |  |  |
| Janssen | Single Dose | | | |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Administration Site: | Left Deltoid | Right Deltoid |  |  |
| Dosage: | 0.25 mL | 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: