



Department of Health

New York State Department of Health
Bureau of Immunization

COVID-19 Immunization Screening and Consent Form*: Children and Adolescents Ages 5 – 12 years old

Recipient Name (please print)		Preferred Name	
DOB	Current Gender ID Indicate ID Below: <input type="text"/>	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: <input type="text"/>	Key: M – Male F – Female I – Intersex NR – Chose not to Respond	Marital Status Indicate Status Below: <input type="text"/>	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: <input type="text"/>	Ethnicity Key: DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown	Race Indicate Race Below: <input type="text"/>	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.	Are you between the ages of 5 and 11 years old?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2.	Are you 12 years old or older?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3.	Are you feeling sick today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4.	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
5.	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: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
6.	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

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 4, 2021