New York State Department of Health
Bureau of Immunization

# COVID-19 Vaccine Screening and Consent Form

## for Moderately to Severely Immunocompromised People

| | | | |
|---|---|---|---|
| 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<br>Indicate ID Below: TM – Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming<br>Q – Not Sure/Questioning NR – Chose not to Respond<br>GNL - Gender not Listed (write-in) * Gender Pronouns: write-in by client's name | | |
| Sex Assigned at Birth **Key:**<br>Indicate Sex Below: M – Male F – Female<br>I – Intersex<br>NR – Chose not to Respond | | Marital Status **Key:** S – Single D – Divorced M – Married<br>Indicate Status Below: W – Widowed V – Civil Union<br>U – Unknown SEPARATED – Legally Separated<br>PARTNER – Life Partner | |
| Ethnicity **Key:** DECL – Declined<br>Indicate Ethnicity Below: HIS – Hispanic Origin<br>NHL – Non-Hispanic Origin<br>UNK – Unknown | | Race **Key:** AIA – Native American or Alaskan ASN – Asian<br>Indicate Race Below: BAA – African American or Black DECL – Declined<br>NHP – Native Hawaiian or Pacific Islander<br>WHT – White OTH – Other or Multiracial | |
| Primary Insurance Name | | Primary Insurance ID# | Subscriber Name/DOB<br>Subscriber Relation to Patient |
| Primary Insurance Address | | Primary Insurance Group # | Primary Insurance Phone # |
| Secondary Insurance Name | | Secondary Insurance ID# | Subscriber Name/DOB<br>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 6 months on the day of your appointment? | □ Yes | □ No | □ Unknown |
| 2. | Are you feeling sick today? | □ Yes | □ No | □ Unknown |
| 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 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 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 asevere 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 transplantand taking immunosuppressive therapy, 3) Receipt of CAR-T-cell or hematopoietic stem cell transplant(within 2 years of transplantation or taking immunosuppression therapy), 4) | □ Yes | □ No | □ Unknown |

| | | | | |
|---|---|---|---|---|
| | 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., 20 mg 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. | | | |
| 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 had Guillain-Barré Syndrome after receipt of the Janssen vaccine? | □ Yes | □ No | □ Unknown |
| 11. | Do you have a history of MIS-C or MIS-A (multisystem inflammatory syndrome in children or multisystem inflammatory syndrome in adults)? | □ Yes | □ No | □ Unknown |
| 12.* | Have you received two previous doses of the Pfizer, or Moderna COVID-19 vaccines, and was your last dose at least 28 days ago? | □ Yes | □ No | □ Unknown |
| 13.* | Have you received a previous dose of the Janssen (Johnson & Johnson) COVID-19 vaccine at least 28 days ago? | □ Yes | □ No | □ Unknown |
| 14** | Are you 5 years to 11 years old and have received 3 doses of the Pfizer COVID-19 vaccine, and was your last dose at least 3 months ago? | □ Yes | □ No | _____ Date: (if applicable) |
| 15.** | Are you 6 years to 11 years old and have received 3 doses of the Moderna COVID-19 vaccine? | □ Yes | □ No | _____ Date: (if applicable) |
| 16.** | Are you 12 years or older and have received 3 doses of the Moderna or Pfizer, or 2 doses of Novavax vaccine, and was your last dose at least 2 months ago? | □ Yes | □ No | _____ Date: (if applicable) |
| 17.** | Have you received 2 doses of a Janssen (Johnson & Johnson) COVID-19 vaccine, or one dose of Janssen (Johnson & Johnson) followed by an mRNA vaccine (Pfizer or Moderna), and was your last dose at least 2 months ago? | □ Yes | □ No | _____ Date: (if applicable) |
| 18. | 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, Nuvaxovid, COVOVAX, or CanSino Biologics – Convidecia)?[1] | □ Yes | □ No | □ Unknown |

***Questions 12 and 13 pertain to eligibility for an additional primary series dose**

****Questions 14, 15, 16, 17 refer to eligibility for a monovalent/bivalent booster dose**

**‡Children under the age of 12 who received Moderna are not eligible for a booster dose at this time.**

[1] As set forth in CDC's Emergency Use Instructions (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 undergonethe 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. The Janssen (Johnson & Johnson) COVID-19 vaccine is EUA authorized for those individuals 18 years old and older. The Novavax COVID-19 vaccine is EUA authorized for those individuals 12 years and older. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 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 through 15 years old, and Moderna COVID-19 vaccine for individuals 6 months through 17 years old 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 12 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 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 applicablevaccine 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 | □ Additional Dose (5 years or older) | □ Monovalent Booster (5 through 11 years old)<br><br>□ Bivalent Booster (≥ 12 years old) | | |
| Moderna | □ First Dose | □ Second Dose | □ Additional Dose (6 months or older) | □ Bivalent Booster (≥ 12 years old) | | |
| Novavax | □ First Dose | □ Second Dose | | □ Bivalent mRNA Booster (≥ 18 years old) | | |
| Janssen | □ Single Dose | □ Additional Dose | | □ Bivalent mRNA Booster (≥ 18 years old) | | |
| 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 September 13, 2022**