Name: _____ **DOB:** _____ **Age:** _____

Address: _____ **Phone:** _____

_____

Please place your *initials* on the line to the left of the answer to each of the following

YES	NO	
_____	_____	**Are you feeling sick today?**
_____	_____	**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?**
_____	_____	**Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days? *If so, when was the last dose?* _____**
_____	_____	**Have you ever had an immediate allergic reaction, such as hives, facial swelling, difficulty breathing or anaphylaxis, to any vaccine or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?**
_____	_____	**Do you have a bleeding disorder, a history of blood clots, or are you taking a blood thinner?**
_____	_____	**Are you pregnant or considering becoming pregnant?**
_____	_____	**Do you have cancer, leukemia, HIV/AIDS, or any other condition that weakens the immune system?**
_____	_____	**Do you take any medications that affect your immune system, such as cortisone, prednisone, or anticancer drugs, or have you had any radiation treatments?**
_____	_____	**Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?**
_____	_____	**Are you 65 years old or older?**
_____	_____	**Are you 18 years old or older AND a resident of a long-term care facility?**
_____	_____	**Are you 18 through 64 years old AND are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting?**
_____	_____	**Are you 50 through 64 years old AND have one or more of the following conditions (due to increased risk of moderate or severe illness or death from the virus that causes COVID-19):** **1.) Cancer (current or in remission, including 9/11-related cancers);** **2.) Chronic kidney disease;**

3.) Pulmonary Disease, including but not limited to, COPD (chronic obstructive pulmonary disease), asthma (moderate-to-severe), pulmonary fibrosis, cystic fibrosis, and 9/11 related pulmonary diseases;
4.) Intellectual and Developmental Disabilities including Down Syndrome;
5.) Heart conditions, including but not limited to heart failure, coronary artery disease, cardiomyopathies, or hypertension (high blood pressure);
6.) Immunocompromised state (weakened immune system) including but not limited to solid organ transplant or from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, use of other immune weakening medicines, or other causes;
7.) Severe Obesity (BMI 40 kg/m2 or higher), Obesity (body mass index [BMI] of 30 kg/m2 or higher but < 40 kg/m2), Overweight (BMI of 25 kg/m2 or higher but < 30kg/m2);
8.) Pregnant;
9.) Sickle cell disease or Thalassemia;
10.) Type 1 or 2 diabetes mellitus;
11.) Cerebrovascular disease (affects blood vessels and blood supply to the brain);
12.) Neurologic conditions including but not limited to Alzheimer's Disease or dementia;
13.) Liver disease;
14.) Current or former smoker; or
15.) Substance use disorder.

YES	NO	
_____	_____	**Are you 18 through 49 years old AND have one or more of the underlying medical conditions listed above, and are seeking a booster because the benefits outweigh the risks?**
_____	_____	**Have you received 2 doses of the Pfizer vaccine, the second dose being at least 6 months ago?**
_____	_____	**Have you received 2 doses of the Moderna vaccine, the second dose being at least 6 months ago?**
_____	_____	**Have you received a previous dose of the Janssen vaccine, at least 2 months ago?**
_____	_____	**Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm/BIBP)?**

Please acknowledge each of the following with initials:

_____ **I understand the risks and benefits of the vaccine and have received the FDA Fact Sheet.**

_____ **I have told the vaccination provider about any pertinent medical conditions and have had all of my questions answered to my satisfaction.**

Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today? (Circle One) **PFIZER** **MODERNA** **JANSSEN/J&J**

Vaccine Name	Administration	EUA Fact Sheet Date	Manufacturer Lot #
Pfizer/BioNTech	___ First ___ Second __ Third	_____	_____
Moderna	___ First ___ Second __ Third	_____	_____
Janssen/J&J	___ First ___ Second __ Third	_____	_____

Administration Site: ___ Left Deltoid ___ Right Deltoid **Dosage**: ___ 0.25mL ___ 0.3 mL ___ 0.5 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: _____

Health Insurance Information

Health Insurance Carrier/Company: _____

Health Insurance ID#: _____

Health Insurance Group #: _____

Health Insurance Claims Address: _____
(only if carrier is unfamiliar)

_____

Previous COVID-19 vaccines administered in NYS? YES / NO * If NO, document dates and lot #'s of previous vaccines

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 booster dose of the COVID-19 vaccine may be recommended at least 2 months following the first dose of Janssen vaccine or at least 6 months following the second dose of Pfizer-BioNTech or Moderna 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.

Patient/Surrogate Signature: _____ Date: _____