



COVID-19 Immunization Screening and Consent Form for EMS

Recipient Name (please print)		Preferred Name	
DOB	Current Gender ID Circle One:	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 Circle One:	Key: M – Male F – Female I – Intersex NR – Chose not to Respond	Marital Status Circle One:	Key: S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner
Address		City	State Zip
Parent/Guardian/ Surrogate (if applicable, please print)		Phone	Email Address
Ethnicity Circle One:	Ethnicity Key: DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown	Race Circle One:	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

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 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
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, 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
5.	Are you pregnant or considering becoming pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
7.	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
8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
10. *	Are you 65 years old or older?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
11. *	Are you 18 years old or older AND a resident of a long-term care facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
12. *	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):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
13. *	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

14. *	Are you 18 through 64 years old AND are at increased risk for COVID-19 exposure and transmission because of working or living in a high-risk setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
15. *	Have you received 2 doses of the Pfizer vaccine, the second dose being at least 6 months ago?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of 2 nd dose: _____ (if applicable)
16. *	Have you received 2 doses of the Moderna vaccine, the second dose being at least 6 months ago?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of 2 nd dose: _____ (if applicable)
17. *	Have you received a previous dose of the Janssen vaccine, at least 2 months ago?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of 1 st dose: _____ (if applicable)
18.	If you had a previous dose of Janssen (Johnson & Johnson), did you develop thrombosis with thrombocytopenia syndrome (TTS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
19.	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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

*Questions #10 - 17 pertain to booster dose eligibility.

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 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, 18 years old or older and a resident of a long term care facility, 50-64 years with an underlying medical condition, 18-49 years old with an underlying medical condition based on individual benefits and risks, 18-64 years old and at an increased risk for COVID-19 exposure and transmission because of working or living in a high-risk setting and 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.

Recipient/Surrogate/Guardian (Signature) recipient	Date / Time	Print Name	Relationship to Patient (if other than recipient)
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AREA BELOW TO BE COMPLETED BY VACCINATOR

Which vaccine is the patient receiving today?			
Vaccine Name	Administration		Booster/Third Doses
Pfizer/ BioNTech	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	<input type="checkbox"/> Third Dose
Moderna	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	<input type="checkbox"/> Third Dose
Astra-Zeneca	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	<input type="checkbox"/> Third Dose
Janssen	<input type="checkbox"/> Single Dose		<input type="checkbox"/> Second Dose

Administration Site Left Deltoid Right Deltoid Left Thigh Right Thigh

Dosage 0.5 ml 0.3 ml 0.25 ml 0.2 mL (Pedi)

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: _____

NYS EMS ID of vaccinator: _____