Saratoga County Public Health
Prevent. Promote. Protect.

COVID-19 Immunization Screening and Consent Form for Saratoga County EMS

Recipient Info			
Recipient Full Legal Name (please print)			**Date of Birth**
Sex Assigned at Birth (check one) ☐ Male ☐ Female ☐ Choose not to Respond	**Phone**	☐ **This is a Mobile Phone Number (check if yes)** ☐ **Opt-In for SMS (Text) Notifications** (Msg & Data rates may apply)	
Address	**City**	**State**	**Zip**
Email Address			
Race (check one) ☐ Native American or Alaskan ☐ Asian ☐ African American or Black ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other or Multiracial ☐ Declined		**Ethnicity** (check one) ☐ Hispanic ☐ Non-Hispanic Origin ☐ Unknown ☐ Declined	
Mother's Maiden Name (please print)	**Initial Vaccine Type** (check one) ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson)	**Date of 1st Dose**	**Date of 2nd Dose**

Screening Questionnaire				
1.	Are you feeling sick today? If yes, you should not receive a vaccine.	☐ Yes	☐ No	**Patient should be counseled appropriately for any YES answers – see info following each screening question.**
2.	In the last 10 days, have you had a COVID-19 test or have you been told to isolate or quarantine at home due to COVID-19 infection or exposure? If yes, you should not be vaccinated until you are off quarantine.	☐ Yes	☐ No	
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? If yes, you need to wait 90 days from your last dose to be vaccinated.	☐ Yes	☐ No	
4.	Have you ever had an immediate allergic reaction (e.g., hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot? If yes, you should be observed for 30 minutes following vaccination.	☐ Yes	☐ No	
5.	Are you pregnant or considering becoming pregnant? If yes, you should discuss COVID vaccination with your OB provider before being vaccinated. Pregnancy is not a contraindication to COVID vaccination.	☐ Yes	☐ No	
6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system or do you take medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments? If yes, you should be aware that the vaccine may not be as effective.	☐ Yes	☐ No	
7.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner? Blood thinners are not a contraindication to COVID vaccination. People with a history of blood clots should not receive the J&J vaccine.	☐ Yes	☐ No	

See consent and vaccination information on back of this form

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 is recommended at least 2 months following the first dose of Janssen vaccine (if I am age 18 or older), or at least 5 months following the second dose of Pfizer-BioNTech (if I am age 5 or older) or Moderna COVID-19 vaccine (if I am age 18 or older), 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) **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**				**Comments**	**Manufacturer & Lot #**
Pfizer/BioTech	☐ 1st Dose	☐ 2nd Dose	☐ 3rd Dose	☐ Booster		
Moderna	☐ 1st Dose	☐ 2nd Dose	☐ 3rd Dose	☐ Booster		
Janssen	☐Single Dose	☐ Booster				

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 part, guardian, or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____ NYS EMS ID of Vaccinator _____

Updated January 24, 2022