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Onondaga County
Health Department
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COVID-19 Immunization Screening and Consent Form

Name *(please print):* _____ **DOB:** _____ **Preferred Language:** _____

Current Gender ID: ☐ Woman/Girl ☐ Transgender Woman/Girl ☐ Man/Boy ☐ Transgender Man/Boy ☐ Non-Binary
☐ Gender Non-Conforming ☐ Not Sure/Questioning ☐ Choose Not to Answer
☐ Gender Not Listed *(write in):* _____ Gender Pronouns *(optional):* _____

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex ☐ Choose Not to Answer

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Civil Union ☐ Legally Separated ☐ Life Partner ☐ Choose Not to Answer

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Email Address: _____ **Phone:** _____

Parent/Guardian/Surrogate Name *(if applicable):* _____

Race: ☐ Native American or Alaskan ☐ African American or Black ☐ Native Hawaiian or Pacific Islander
☐ Asian ☐ White ☐ Other or Multiracial ☐ Choose Not to Answer

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Unknown ☐ Choose Not to Answer

Primary Insurance: _____ ID#: _____ Group #: _____

Insurance Address: _____ Insurance Phone Number: _____

Subscriber's Name: _____ DOB: _____ Relation to Patient: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Insurance Address: _____ Insurance Phone Number: _____

Subscriber's Name: _____ DOB: _____ Relation to Patient: _____

Primary Care Physician: _____ Phone: _____

Clinic/Office Where Vaccine is Being Administered: _____

Screening Questionnaire

1.	Are you feeling sick today?	☐ Yes ☐ No
2.	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate at home due to COVID-19 infection?	☐ Yes ☐ No ☐ Unknown
3.	In the last 10 days, have been told by a healthcare provider or health department to quarantine at home due to COVID-19 exposure or travel?	☐ 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 was your **last** dose? Date: _____	☐ Yes ☐ No ☐ Unknown
5.	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, such as polyethylene glycol (PEG) or polysorbate?	☐ Yes ☐ No ☐ Unknown
6.	Have you had any vaccines in the past 14 days (2 weeks) including a flu shot? **If yes,** how long ago was your **most recent** vaccine? Date: _____	☐ Yes ☐ No ☐ Unknown
7.	Are you pregnant or considering becoming pregnant?	☐ Yes ☐ No ☐ Unknown
8.	Do you have cancer, leukemia, HIV /AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes ☐ No ☐ Unknown
9.	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?	☐ Yes ☐ No ☐ Unknown
10.	Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No ☐ Unknown
11.	Have you received a previous dose of COVID-19 vaccine? **If yes,** date: _____	☐ Yes ☐ No ☐ Unknown

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 undergone the 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.

Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if I am administered (given) Pfizer or Moderna vaccine, that I will need two doses of the vaccine in order for it to be effective. 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 vaccine 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 Signature (or parent/surrogate/guardian)	*Print Name*	*Relationship to Patient (if not recipient)*	*Date*

If an interpreter was used to complete this form:

_____ **OR**	_____	_____	_____
Telephonic Interpreter's ID #	*In-Person Interpreter (Signature)*	*Print Name*	*Date*

Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today?

Vaccine Name	*Administration*		*EUA Fact Sheet Date*	*Manufacturer and Lot Number*
Pfizer/BioNTech	☐ First Dose	☐ Second Dose		
Moderna	☐ First Dose	☐ Second Dose		
Janssen/Johnson & Johnson	☐ Single Dose			

Administration Site: ☐ Left Deltoid ☐ Right Deltoid

Dosage: ☐ 0.5 ml ☐ 0.3 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