SPRINGBROOK

COVID-19 Immunization Screening and Consent Form

Name (print): _____ Mothers' Maiden Name: _____

Address: _____

Phone Number: (_____)_____-_____ Date of Birth: _____ / _____ /_____ Age: _____

☐ Yes ☐ No Check box for permission to add your information to the NYS Immunization Information System

Screening Questions

Are you feeling sick today?	☐ Yes	☐ No
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
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
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?	☐ Yes	☐ No
Are you pregnant or considering becoming pregnant?	☐ Yes	☐ No
Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	☐ Yes	☐ No
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
Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	☐ Yes	☐ No

Qualifying Elements

Are you 50 years old or older?	☐ Yes	☐ No
Are you 18 years old or older AND a resident of a long-term care facility?	☐ Yes	☐ No
Are you 50 through 64 years old AND have one or more of the conditions listed on the back (due to increased risk of moderate or severe illness or death from the virus that causes COVID-19)?	☐ Yes	☐ No
Are you 18 through 49 years old AND have one or more of the underlying medical conditions listed on the back, and are seeking a booster because the benefits outweigh the risks?	☐ Yes	☐ No
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?	☐ Yes	☐ No
Have you received 2 doses of the Pfizer vaccine, the second dose being at least 5 months ago?	☐ Yes	☐ No
Have you received 2 doses of the Moderna vaccine, the second dose being at least 5 months ago?	☐ Yes	☐ No
Have you received a previous dose of the Janssen vaccine, at least 2 months ago?	☐ Yes	☐ No
Have you received either a Pfizer, Moderna, or Janssen booster dose at least 4 months ago?	☐ Yes	☐ No

For 2nd Moderna Booster Qualifying Elements

Adults ages 50 years and older who are not moderately or severely immunocompromised may choose to receive a second booster dose using an mRNA COVID-19 vaccine at least 4 months after the first booster dose

Adults ages 18–49 years who are not moderately or severely immunocompromised and who received Janssen COVID-19 Vaccine as both their primary series dose and booster dose may receive a second booster dose using an mRNA COVID-19 vaccine at least 4 months after the first Janssen booster dose

Adults ages 18 and older who are moderately or severely immunocompromised conditions can get a second Moderna booster at least 4 months after their first booster

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.

Signature: _____ Print Name: _____ Date: ___ / ___ / _____

COVID-19 Immunization Screening and Consent Form

Qualifying Elements - #12-13, underlying medical conditions

1.) Cancer (current or in remission, including 9/11-related cancers);

2.) Chronic kidney disease;

3.) Pulmonary Disease, limited to, COPD (chronic obstructive pulmonary disease), asthma (moderate-to-severe), pulmonary fibrosis, cystic fibrosis, tuberculosis, 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 or recently 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 limited to cirrhosis, non-alcoholic fatty liver disease, alcoholic liver disease, or autoimmune hepatitis;

14.) Current or former smoker;

15.) Substance use disorder,

16) Mental health disorders limited to mood disorders including depression, schizophrenia spectrum disorders.

Area Below to be Completed by Vaccinator					
Vaccine Name	Dose	Date	EUA Fact Sheet Date	Site	
Moderna 0.25mL Dose	Booster	__ /__ /____	___ /___ /_____	__Left __Right	

I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable). I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

Vaccinator Signature: _____ Date: ___ / ___ / ___