COVID-19 VACCINE BOOSTER / 3RD DOSE ATTESTATION

THIS FORM MUST BE COMPLETED & SENT WITHIN 24 HOURS OF APPOINTMENT. PLEASE BRING THIS PAGE TO THE APPOINTMENT AS WELL!

Recipient Name: _____ **Date of Birth:** _____

☐ **I attest that I am eligible for a booster dose of vaccine based on the criteria below:**

- ➢ **<u>I received a second dose of Pfizer COVID-19 vaccine at least 6 months ago, AND</u>**
  - I am age 65 years or older, OR
  - I live in a long-term care setting, OR
  - I am age 18-64 and am at increased risk for COVID-19 exposure and transmission because of my work (healthcare workers, teachers, public servants, etc.) or institutional setting, OR
  - I am age 18-64 and I have one of the following underlying medical conditions:

    Cancer; Chronic kidney disease; Chronic lung disease, including COPD (chronic obstructive pulmonary disease); asthma (moderate-to-severe); interstitial lung disease; cystic fibrosis, and pulmonary hypertension; Dementia or other neurological conditions; Diabetes (type 1 or type 2); Down syndrome; Heart conditions (such as heart failure, coronary artery disease, cardiomyopathies or hypertension); HIV infection; Immunocompromised state (weakened immune system); Liver disease; Overweight or obesity (body mass index (BMI) over 25 kg/m2; Pregnant and recently pregnant (for at least 42 days following end of pregnancy); Sickle cell disease or thalassemia; Smoker; current or former; Solid organ or blood stem cell transplant; Stroke or cerebrovascular disease, which affects blood flow to the brain; Substance use disorder

☐ **I attest that I am immunocompromised and am eligible for a third dose of vaccine based on the criteria below:**

- ➢ **<u>I received a second dose of Moderna or Pfizer vaccine at least 28 days ago, AND</u>**
  - I am receiving active cancer treatment for tumors or cancers of the blood, OR
  - I have received an organ transplant and am taking medicine to suppress my immune system, OR
  - I have received a stem cell transplant within the last 2 years or am taking medicine to suppress the immune system, OR
  - I have moderate or severe primary immunodeficiency (such as DiGeorge syndrome, WiskottAldrich syndrome), OR
  - I have advanced or untreated HIV infection, OR
  - I have active treatment with high-dose corticosteroids or other drugs that suppress my immune response

Signature of Vaccine Recipient or Parent (if under 18): _____

Print Parent Name (if under 18): _____ **Date of Service (your appointment):** _____