



# PART 1: COVID-19 VACCINE INTAKE FORM

FORMS MUST BE COMPLETED IN ADVANCE OF APPOINTMENT.  
PLEASE BRING TO YOUR APPOINTMENT. NO FORMS = NO VACCINE

## VACCINE RECIPIENT - ALL FIELDS REQUIRED

**Recipient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Birth Sex:**  Female  Male

**Race:**  American Indian/Alaskan Native  Asian  Black/African American  
 Hawaiian Native/Pacific Islander  White (mark all that apply)

**Ethnicity:**  Hispanic  Non-Hispanic

**Address:** \_\_\_\_\_ **Apt #:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**Cell Phone Number:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_  
contact name phone number relationship to patient

## INSURANCE

\*\*\* PLEASE FILL OUT & ALSO SEND COPIES/PHOTOS OF YOUR/YOUR CHILD'S INSURANCE CARD \*\*\*

**Insurance Provider:** \_\_\_\_\_ **Member ID:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Are you the policy subscriber?**  Yes  No → **If no, please provide:** \_\_\_\_\_  
subscriber name DOB relationship to patient

\*\*\* If you do not have ACTIVE health insurance, please check this box AND write your SSN or State ID/Driver's License # in order for the government to reimburse Heights Pediatrics for your vaccine:

I currently do not have health insurance. SSN / State ID / Driver's License #: \_\_\_\_\_

## VACCINE INFO

**Have you received a previous dose of the COVID-19 vaccine?**  Moderna  Pfizer  Other → **Date(s):** \_\_\_\_\_

## MANDATORY NEW YORK STATE FORM - FIRST DOSES ONLY

Visit link or scan QR code to complete: [vaccineform.health.ny.gov](https://vaccineform.health.ny.gov) ----->

Provide screenshot of submission OR

Write your submission ID: \_\_\_\_\_



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

Print Parent Name (if under 18): \_\_\_\_\_ Date of Service (your appointment): \_\_\_\_\_



# PART 2: COVID-19 VACCINE SCREENING & CONSENT

**THIS FORM MUST BE COMPLETED WITHIN 24 HOURS OF APPOINTMENT.  
PLEASE BRING TO THE APPOINTMENT!**

**Recipient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Have you received a previous dose of the COVID-19 vaccine?**  Moderna  Pfizer  Other → Date: \_\_\_\_\_

**If you answer “Yes” to any questions below, please call us and speak to the doctor before your appointment:**

	Yes	No	Don't Know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	
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, exposure or travel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?</i> Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you carry an epipen? Or 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 have you had a severe allergic reaction (anaphylaxis) to anything?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any medical conditions for which you receive any type of treatment? (e.g. asthma, heart disease, etc.) Please list below: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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. Please note: FDA approved Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including those individuals 12 through 15 years of age and for the administration of a third dose in populations set forth in the consent section below.

**Consent** | By signing, 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. 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 any monies/benefits 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 of Vaccine Recipient or Parent (if under 18):** \_\_\_\_\_

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



# COVID-19 VACCINE BOOSTER / 3RD DOSE ATTESTATION

FORMS MUST BE COMPLETED IN ADVANCE OF APPOINTMENT.  
PLEASE BRING TO YOUR APPOINTMENT. NO FORMS = NO VACCINE

Recipient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

➤ **I received a second dose of Pfizer COVID-19 vaccine at least 6 months ago, AND**

- 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/m<sup>2</sup>); 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:

➤ **I received a second dose of Moderna or Pfizer vaccine at least 28 days ago, AND**

- 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): \_\_\_\_\_