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

PREVIOUS COVID-19 VACCINE INFO

Date of 1st dose: _____ ▫ Pfizer ▫ Moderna ▫ Other: _____ ▫ None

Date of 2nd dose: _____ ▫ Pfizer ▫ Moderna ▫ Other: _____ ▫ None

Date of 3rd dose: _____ ▫ Pfizer ▫ Moderna ▫ Other: _____ ▫ None

Additional doses: _____

FIRST DOSES ONLY - MANDATORY NEW YORK STATE FORM

Visit link or scan QR code to complete: vaccineform.health.ny.gov ---------->

SCAN ME

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:** _____

Which dose are you receiving during this visit? ☐ 1st ☐ 2nd ☐ 3rd or Booster#1 ☐ 4th or Booster#2

Do you attest that you are eligible for this dose based on current CDC guidelines (as of your appt date)? ☐ Yes

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?	☐	☐	
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?	☐	☐	☐
3.	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: _____	☐	☐	☐
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?	☐	☐	☐
5.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐	☐	☐
6.	Do you have any medical conditions for which you receive any type of treatment? (e.g. asthma, heart disease, etc.) Please list below: _____	☐	☐	☐
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?	☐	☐	☐
8.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐

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):** _____