Department of Homeless Services
Department of Social Services

COVID-19 Immunization Screening and Consent Form*

Recipient Name (please print)

Preferred Name and pronoun

DOB

Current Gender:
- ☐ Woman/Girl
- ☐ Transgender Woman/Girl
- ☐ Man/Boy
- ☐ Transgender Man/Boy
- ☐ Non-Binary Person
- ☐ Gender Non-Conforming
- ☐ Not Sure/Questioning
- ☐ Chose not to Respond
- ☐ Gender not Listed (write-in)

Sex Assigned at Birth
- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Chose not to Respond

Marital Status
- ☐ Single
- ☐ Divorced
- ☐ Married
- ☐ Widowed
- ☐ Civil Union
- ☐ Legally Separated
- ☐ Life Partner
- ☐ Unknown

Address **City** **State** **Zip**

Email Address

Parent/Guardian/ Surrogate (if applicable, please print)

Phone

Preferred Language

Ethnicity
- ☐ Hispanic Origin
- ☐ Non-Hispanic Origin
- ☐ Unknown
- ☐ Declined

Race
- ☐ Native American or Alaskan
- ☐ Asian
- ☐ African American or Black
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other or Multiracial
- ☐ Declined

Primary Insurance Name	**Primary Insurance ID#**	**Subscriber Name/DOB**	**Subscriber Relation to Patient**
Primary Insurance Address	**Primary Insurance Group #**	**Primary Insurance Phone #**	
Secondary Insurance Name	**Secondary Insurance ID#**	**Subscriber Name/DOB**	**Subscriber Relation to Patient**
Secondary Insurance Address	**Secondary Insurance Group #**	**Secondary Insurance Phone #**	

Clinic/Office Site Where Vaccine is Administered

Primary Care Physician Address/Phone Number

	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 did you receive the last dose?*	☐ 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 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?	☐ Yes	☐ No	Date: ___________ (if applicable)

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 vaccine. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses of this 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 vaccination as described.

I understand that it is my choice to receive or not receive the COVID-19 vaccine. If I decide not to receive the vaccine, my eligibility and receipt of services from the NYC Department of Homeless Services will not be affected.

I request that the COVID-19 vaccine 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. I also authorize information about my vaccination to be forwarded to the NYC Department of Homeless Services.

Recipient/Surrogate/Guardian (Signature) Date / Time Print Name Relationship to patient, if other than recipient

Telephonic Interpreter's ID # Date / Time

OR

Signature: Interpreter Date/ Time Print: Interpreter's Name and Relationship to Patient

Area Below to be Completed by Vaccinator			
Which vaccine is the patient receiving today?			
Vaccine Name	Administration	EUA Fact Sheet Date	Manufacturer & Lot Number

Pfizer/ BioNTech	☐ First Dose	☐ Second Dose		
Moderna	☐ First Dose	☐ Second Dose		
Astra-Zeneca	☐ First Dose	☐ Second Dose		
Janssen	☐ Single Dose			

Administration Site ☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh

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: ____