COVID-19 Vaccination Program Guidance

Priority Groups Eligible to be Vaccinated

All individuals age 5 and older are eligible to receive a Pfizer COVID-19 vaccine. However, minors ages 5 to 17 are NOT authorized to receive the Janssen or Moderna COVID-19 Vaccines. Individuals under 5 years of age are not currently eligible to receive ANY COVID-19 vaccine.

Minor Consent

For the purposes of this document, a minor is defined as an individual under the age of 18 years. Minors need parental or guardian consent to receive a COVID-19 vaccine, except in the rare instance where the minor is part of a group to whom the law gives the right to consent to their own care (e.g., emancipated minors, married minors, minors who are parents or pregnant, and minors in the military).

In general, it is strongly encouraged that a parent or legal guardian accompany a minor age 5 to 17 years to provide in-person consent for vaccination at each dose.

Vaccine Support/Medical Documentation Staff must document in the CDMS/Microsoft Notes section the name of the person providing consent for the minor. Verbal consent is allowed.

If a minor is unaccompanied, the provider will attempt to contact the parent or guardian by phone with a witness listening at the time of the minor’s vaccination to provide consent to the provider. Providers can accept a written statement of consent from the parent or guardian, where the parent or guardian is not available by phone to provide consent to vaccinate an unaccompanied minor. The ECDOH COVID-19 Immunization Screening and Consent form may be considered for this purpose.

Erie County Department of Health will follow the above guidelines. All minors unaccompanied by a parent or guardian MUST bring the completed NYS COVID-19 Immunization Screening and Consent Form to the clinic or be able to contact parent or legal guardian by phone to provide consent. The Minor must also bring proof of date of birth (birth certificate, passport, learning permit/driver’s license, benefits care, etc.) and photo ID (passport, learning permit/driver’s license, school ID, etc.)
# COVID-19 Immunization Screening and Consent Form*

<table>
<thead>
<tr>
<th>Recipient Name (please print)</th>
<th>Preferred Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOB</strong></td>
<td><strong>Preferred Name</strong></td>
</tr>
</tbody>
</table>

**Current Gender ID Key:**
- W – Woman/Girl
- TW – Transgender Woman/Girl
- M – Man/Boy
- TM – Transgender Man/Boy
- NB – Non-Binary Person
- GNC – Gender Non-Conforming
- Q – Not Sure/Questioning
- NR – Chose not to Respond
- GNL - Gender not Listed (write-in)

**Sex Assigned at Birth Key:**
- M – Male
- F – Female
- I – Intersex
- NR – Chose not to Respond

**Marital Status Key:**
- S – Single
- D – Divorced
- M – Married
- W – Widowed
- V – Civil Union
- U – Unknown
- SEPARATED – Legally Separated
- PARTNER – Life Partner

**Address**
- **City**
- **State**
- **Zip**
- **Email Address**

**Parent/Guardian/ Surrogate (if applicable, please print)**
- **Phone**
- **Preferred Language**

**Ethnicity**
- **Ethnicity Key:**
  - DECL – Declined
  - HIS – Hispanic Origin
  - NHL – Non-Hispanic Origin
  - UNK – Unknown

**Race**
- **Race Key:**
  - AIA – Native American or Alaskan
  - ASN – Asian
  - BAA – African American or Black
  - DECL – Declined
  - NHP – Native Hawaiian or Pacific Islander
  - WHT – White
  - OTH – Other or Multiracial

**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 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  □ Unknown
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:   □ Yes  □ No  □ Unknown
4. 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  □ Unknown
5. Are you pregnant or considering becoming pregnant?  □ Yes  □ No  □ Unknown

* Gender Pronouns: write-in by client’s name
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 is an FDA-approved COVID-19 vaccine (brand name Comirnaty, mRNA) to prevent COVID-19 in persons 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 5 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

**Emergency Use Authorization**

Emergency Use Instructions (EUIs) are issued by the CDC to provide information about emergency use of FDA-approved medical products that may not be included in or differ in some way from the information provided in the FDA-approved labeling (package insert). The COVID-19 vaccine by Pfizer-BioNTech is an FDA-approved COVID-19 vaccine (brand name Comirnaty, mRNA) to prevent COVID-19 in persons 16 years of age and older. CDC is issuing EUI to provide information about use of this vaccine as an additional primary dose in certain immunocompromised persons (12 years of age and older) and a booster dose in certain adults (18 years of age and older) who received certain non-FDA authorized or approved COVID-19 vaccine (e.g., certain vaccines available outside of the United States or from clinical trial participation).

**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 is recommended at least 2 months following the first dose of Janssen vaccine (if I am age 18 or older), or at least 6 months following the second dose of Pfizer-BioNTech (if I am age 16 or older) or Moderna COVID-19 vaccine (if I am age 18 or older), 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.

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<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7.</td>
<td>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?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8.</td>
<td>Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9.</td>
<td>Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10.</td>
<td>Are you 16 years old or older, and have you received 2 doses of the Pfizer vaccine, the second dose being at least 6 months ago?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11.</td>
<td>Have you received 2 doses of the Moderna vaccine, the second dose being at least 6 months ago?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12.</td>
<td>Have you received a previous dose of the Janssen vaccine, at least 2 months ago?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>13.</td>
<td>If you had a previous dose of Janssen (Johnson &amp; Johnson), did you develop thrombosis with thrombocytopenia syndrome (TTS)?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>14.</td>
<td>Have you received a previous dose of a non-FDA authorized or approved COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – COVAXIN, Serum Institute of India – COVISHELD, Sinopharm/BIBP, COVAXIN)?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

*Questions #10 - 14 pertain to booster dose eligibility.

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1 As set forth in the CDC’s Emergency Use Instructions, a non-FDA authorized or approved COVID-19 vaccine such as those vaccines “listed for emergency use by the World Health Organization, or is included in CDC’s Technical Instructions for Implementing Presidential Proclamation Advancing Safe Resumption of Global Travel During the COVID-19 Pandemic and CDC’s Order, or that is a non-placebo part of a clinical trial within or outside the United States that is a WHO-EUL COVID-19 vaccine or a vaccine that is not listed for emergency use by WHO but for which a U.S. data and safety monitoring board or equivalent has independently confirmed efficacy in the United States (hereinafter “non-FDA authorized or approved COVID-19 vaccines”).

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

Telephonic Interpreter’s ID #  Date / Time
OR

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

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**Area Below to be Completed by Vaccinator**

<table>
<thead>
<tr>
<th>Vaccine Name</th>
<th>Administration</th>
<th>EUA Fact Sheet Date</th>
<th>Manufacturer &amp; Lot #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pfizer/BioNTech</td>
<td>□ First Dose</td>
<td>□ Second Dose</td>
<td>□ Booster Dose</td>
</tr>
<tr>
<td>Moderna</td>
<td>□ First Dose</td>
<td>□ Second Dose</td>
<td>□ Booster Dose</td>
</tr>
<tr>
<td>Janssen</td>
<td>□ Single Dose</td>
<td>□ Booster Dose</td>
<td></td>
</tr>
</tbody>
</table>

**Administration Site**

- □ Left Deltoid
- □ Right Deltoid
- □ Left Thigh
- □ Right Thigh

**Dosage**

- □ 0.5 ml
- □ 0.3 ml
- □ 0.25 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: ________________________________

* Use of this form is optional.

Updated December 10, 2021