# 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.)

New York State Department of Health
Bureau of Immunization

## COVID-19 Immunization Screening and Consent Form:* Children and Adolescents Ages 5 – 11 years old

| | | | |
|---|---|---|---|
| Recipient Name (please print) | | Preferred Name | |
| DOB | Current Gender ID<br>Indicate ID Below: ☐ | **Key:**<br>W – Woman/Girl TW – Transgender Woman/Girl M – Man/Boy<br>TM – Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming<br>Q – Not Sure/Questioning NR – Chose not to Respond<br>GNL - Gender not Listed (write-in)<br>* Gender Pronouns: write-in by client's name | |
| Sex Assigned at Birth<br>Indicate Sex Below: ☐ | **Key:**<br>M – Male F – Female<br>I – Intersex NR – Chose not to Respond | Marital Status<br>Indicate Status Below: ☐ | **Key:**<br>S – Single D – Divorced M – Married<br>W – Widowed V – Civil Union U – Unknown<br>SEPARATED – Legally Separated<br>PARTNER – Life Partner |
| Address | City State Zip | Email Address | |
| Parent/Guardian/ Surrogate (if applicable, please print) | | Phone | Preferred Language |
| Ethnicity<br>Indicate Ethnicity Below: ☐ | **Ethnicity Key:**<br>DECL – Declined<br>HIS – Hispanic Origin<br>NHL – Non-Hispanic Origin<br>UNK – Unknown | Race<br>Indicate Race Below: ☐ | **Race Key:**<br>AIA – Native American or Alaskan ASN – Asian<br>BAA – African American or Black<br>DECL – Declined<br>NHP – Native Hawaiian or Pacific Islander<br>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 between the ages of 5 and 11 years old? | ☐ Yes | ☐ No | |
| 2. | Are you 12 years old or older? | ☐ Yes | ☐ No | |
| 3. | Are you feeling sick today? | ☐ Yes | ☐ No | |
| 4. | 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 orquarantine at home due to COVID-19 infection or exposure? | ☐ Yes | ☐ No | ☐ Unknown |
| 5. | 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 |
| 6. | 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 |

| | | | | |
|---|---|---|---|---|
| 7. | Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system? | □ Yes | □ No | □ Unknown |
| 8. | 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 |
| 9. | Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner? | □ Yes | □ No | □ Unknown |
| 10. | Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)? | □ Yes | □ No | □ Unknown |
| 11. | Have you received a previous dose of the Pfizer, Moderna, or Janssen vaccine? | □ Yes | □ No | |
| 12. | Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm/BIBP, COVAXIN)? | □ Yes | □ No | □ Unknown |

**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 the 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 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.

**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 may be recommended at least 2 months following the first dose of Janssen vaccine or at least 6 months following the second dose of Pfizer-BioNTech or Moderna COVID-19 vaccine if I am a member of a certain population (e.g., 65 years or older, 18 years old or older and a resident of a long term care facility, 50-64 years with an underlying medical condition, 18-49 years old with an underlying medical condition based on individual benefits and risks, 18-64 years old and at an increased risk for COVID-19 exposure and transmission because of working or living in a high-risk setting and based on individual benefits and risks) 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.

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

| Telephonic Interpreter's ID # **OR** | Date / Time | |
|---|---|---|
| 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 # |
|---|---|---|---|---|---|
| Pfizer/BioNTech | □ First Dose | □ Second Dose | | | |
| Moderna | NA | NA | | | |
| Janssen | NA | | | | |

| | | | | |
|---|---|---|---|---|
| Administration Site | □ Left Deltoid | □ Right Deltoid | □ Left Thigh | □ Right Thigh |
| Dosage | | □ 0.3 ml | □ 0.2 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 November 8, 2021**