

\* = Required Field

# NYSDOH COVID-19 Vaccine

Moderna\_\_\_\_\_Pfizer\_\_\_\_\_Johnson & Johnson\_\_\_\_\_

Date\_\_\_\_\_Clinic\_\_\_\_\_

## Recipient Information

\* First Name MI \* Last Name

\* Address Apt#

\* City \* State \* Zip \* County

Email Address

\* Date of Birth (MM/DD/YYYY) \* Phone Number \* POD ID

Mother's First Name Mother's Maiden(Last) Name Gender

## Emergency Contact

First Name MI Last Name

Phone Number Relationship to Recipient:

## Primary Care Provider

First Name Last Name

City State Zip Phone Number

Questions for the person receiving Countermeasure (circle the appropriate answer) Screener Initials:

Questions for the person receiving Countermeasure (circle the appropriate answer)	Screener Initials:				Yes	No	Unknown
1. Are you currently under the age of 18?					Y	N	U
2. Are you feeling sick today?					Y	N	U
3. In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home?					Y	N	U
4. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)?					Y	N	U
5. Have you ever had an immediate allergic reaction, such as hives, facial swelling, or difficulty breathing or anaphylaxis, to any vaccine or shot or to any component of the COVID-19 vaccine, such as PEG or polysorbate?					Y	N	U
6. Are you pregnant or considering becoming pregnant?					Y	N	U
7. Do you have a bleeding disorder or are you currently taking a blood thinner?					Y	N	U
8. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?					Y	N	U
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?					Y	N	U
10. Have you ever received a dose of the COVID-19 vaccine?					Y	N	U
11. I have read the entire list of priority groups for COVID-19 vaccination provided in the link above. I hereby certify that I am part of a priority group identified for COVID-19 vaccination, for the week that I am being vaccinated.  I further agree that by clicking and selecting "Yes" and submitting this form, I am placing the legal equivalent of my handwritten signature on such certification.					Y	N	U

For Staff Use Only																									
<b>Disposition at Triage:</b>				<b>Disposition at Evaluation:</b>																					
Referred for Countermeasure				Referred for Countermeasure																					
Referred for Medical Evaluation				Referred for Medical Care																					
Countermeasure Declined				Countermeasure deferred due to Medical Contraindication																					
Other				Other																					
* Date of Visit (MM/DD/YYYY)				<div></div> <div></div> / <div></div> <div></div> / <div></div> <div></div> <div></div> <div></div>																					
<b>Countermeasure 1</b>				<b>Administration Site:</b>																					
<div>Barcode #1</div> <div></div> <div>Place Countermeasure Barcode#1 Here</div>				Left Arm		Right Arm		Left Thigh		Right Thigh		Nasal		Oral		Left Deltoid		Right Deltoid		Left Buttock		Right Buttock		Other	
				Total Administered				<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Total Dispensed				<div></div>	<div></div>	<div></div>	<div></div>	<div></div>				
				<b>Person Providing Countermeasure</b>																					
				First Name				<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>				
				Last Name				<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>				
				Provider Professional License #								<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>								
				Return Visit Date (MM/DD/YYYY)								<div></div>	<div></div>	/	<div></div>	<div></div>	/	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>			
<b>Countermeasure 2</b>				<b>Administration Site:</b>																					
<div>Barcode #2</div> <div></div> <div>Place Countermeasure Barcode#2 Here</div>				Left Arm		Right Arm		Left Thigh		Right Thigh		Nasal		Oral		Left Deltoid		Right Deltoid		Left Buttock		Right Buttock		Other	
				Total Administered				<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Total Dispensed				<div></div>	<div></div>	<div></div>	<div></div>	<div></div>				
				<b>Person Providing Countermeasure</b>																					
				First Name				<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>				
				Last Name				<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>				
				Provider Professional License #								<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>								
				Return Visit Date (MM/DD/YYYY)								<div></div>	<div></div>	/	<div></div>	<div></div>	/	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>			
<b>Comments</b>																									