Niagara County Department of Health
COVID-19 Immunization Minor Consent and Screening Form

Recipient Name **First** **Middle** **Last**	
Date of Birth (MM/DD/YYYY) _____/_____/_____.	**Gender** ☐ Male ☐ Female ☐ Other
Race ☐ Native American or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ Multiracial ☐ White ☐ Other ☐ Unknown ☐ No Response	**Ethnicity** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ No Response
Address **City** **State** **Zip Code**	
Parent/Guardian/Surrogate **Name** **Relationship**	
Phone (XXX-XXX-XXXX)	**Email**

	Screening Questionnaire	
1.	Will the recipient be under the age of 12 on the day of their appointment?	☐ Yes ☐ No ☐ Unknown
2.	Is the recipient feeling sick today?	☐ Yes ☐ No ☐ Unknown
3.	In the last 10 days, has the recipient had a COVID-19 test because they had symptoms or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes ☐ No ☐ Unknown
4.	Has the recipient been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? If yes, when did you receive the last dose?	☐ Yes ☐ No ☐ Unknown
5.	Has the recipient ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, and 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
6.	Is the recipient pregnant or considering becoming pregnant?	☐ Yes ☐ No ☐ Unknown
7.	Does the recipient have a bleeding disorder or take a blood thinner?	☐ Yes ☐ No ☐ Unknown

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8.	Does the recipient have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes ☐ No ☐ Unknown
9.	Does the recipient take any medications that affect their immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐ Yes ☐ No ☐ Unknown
10.	Does the recipient have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	☐ Yes ☐ No ☐ Unknown
11.	Has the recipient received a previous dose of the Pfizer, Moderna or Janssen COVID-19 vaccine?	☐ Yes ☐ No ☐ Unknown
12.	Have you received a previous dose of a COVID-19 vaccine recognized by the WHO but NOT by the FDA (AstraZeneca - VAXZEVRIA, Sinovac - CORONAVAC, Serum Institute of India - COVISHIELD, Sinopharm)?	☐ 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.

Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if the vaccine requires two doses, the person named above 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 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 Parent/Surrogate/Guardian (Signature) Date / Time

_____

Print Name Relationship to patient, if other than recipient

OR

_____

Telephonic Witness Print Name / Signature Date / Time

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