statcare
Urgent & Walk-In Medical Care

COVID-19 Immunization Screening and Consent Form

COVID-19 Vaccine Recipient Name (please print)			Preferred Name	
Date Of Birth	Legal Gender	Gender ID	Marital Status **(see key below):** **S**— Single **D**— Divorced **M**— Married **W**— Widowed **V—** Civil Union **U**— Unknown Separated — Legally Separated PARTNER — Life	
Address, City, State, Zip				Email Address
Parent/Guardian/ Surrogate (if applicable, please print)			Phone	Preferred Language
Ethnicity **(see key below):** **DECL**— Declined **HIS** — Hispanic Origin **NHL** — Non-Hispanic **UNK** — Origin Unknown			**Race (see key below):** **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	
Statcare Site Where Vaccine is Administered: Hicksville, Astoria, Brooklyn, Bronx (Bartow), Bronx (174th St.), Jackson Heights Mobile/trailer Sites: Kiki, Momo, Bobo			Primary Care Physician Address: Phone Number	

	Screening Questionnaire			
1.	Are you feeling sick today?	☐ Yes	☐ No	☐ Unknown
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 or quarantine at home due to it?	☐ Yes	☐ No	☐ Unknown
3.	Have you 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
4.	Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?	☐ Yes	☐ No	☐ Unknown
5.	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?*	☐ Yes	☐ No	☐ Unknown
6.	Are you pregnant or considering becoming pregnant?	☐ Yes	☐ No	☐ Unknown
7.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease 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	☐ 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 completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent:

1. In order to have the COVID-19 vaccine administered ("the COVID-19 vaccine") you must provide written informed consent by signing this document. The purpose of this informed consent is to provide you with enough information so you can understand the possible risks and benefits of receiving the COVID-19 vaccine and authorize Statcare Urgent & Walk-in Medical Care (hereafter "Statcare") to use and disclose your health information for purposes related to review of the safety, efficacy and future use of The COVID-19 vaccine, including disclosure to the manufacturer.
2. By signing this form, I am agreeing to receive the COVID-19 vaccine, which is an investigational vaccine developed to attempt to prevent COVID-19. I have been provided and have read or had explained to me the Fact Sheet for Patients from the vaccine manufacturer (appended to this consent) before I signed this consent. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be

effective. Therefore, I agree that (i) I will return for the second dose if I want it to be effective; (ii) I will inform Statcare prior to receiving the second dose if I have had any problems with or since the first dose; and (iii) this consent form shall apply and be in effect for both doses.

3. I have been given an opportunity 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, risks, and alternatives of the vaccination as described by my provider, including knowing and agreeing that one of the alternatives is not to receive the COVID-19 vaccine.
4. Your records may be shared with the manufacturer of the COVID-19 vaccine or with any regulatory body, including the New York State or New York City immunization registries or for purpose of assessing safety and/or effectiveness of the COVID-19 vaccine or if adverse events related to the COVID-19 vaccine need to be reported.
5. Your receipt of this COVID-19 vaccine is voluntary. You may choose not to receive the vaccine. If you decide not to get the COVID-19 vaccine, it will have no effect on any services or treatment you are currently receiving from your healthcare provider or the Statcare or your employment at the Statcare.
6. 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 insurance plan, Medicare, Medicaid 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.
7. In consideration of Statcare's agreement to administer the COVID-19 vaccine, I hereby agree to release Statcare and any of its employees, agents and representatives ("Releasees"), from any and all liability related to or in connection with the administration of the COVID-19 vaccine, regardless of the reason that I may wish to bring a claim against a Releasee, and even if Releasee(s) were negligent or careless with regards to the administration of the COVID-19 vaccine. This means that I will not sue Releasees for anything related to the administration of the COVID-19 vaccine including any future side effects. I realize that lawsuits relating to the COVID-19 vaccine may be precluded under federal law. I realize that (i) this Release covers events after the signing of this document, and that the exact nature of any injury or loss that may be claimed may not be entirely foreseeable; (ii) the terms of this Release mean that I am waiving certain rights; and (iii) if any portion of this. Release is determined to be invalid or unenforceable, that portion shall be severable, and the balance of the Release shall not be affected in any way and shall continue in full legal force and effect. Any disputes will be governed by the laws of the State of New York and agree to and acknowledge the above, and wish to receive the COVID-19 vaccine.
8. 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 HAVE READ THOROUGHLY THIS CONSENT FORM AND THE PATIENT INFORMATION SHEET, AND ANY QUESTIONS I HAVE ABOUT GOING AHEAD WITH THE COVID-19 VACCINE AT THIS TIME HAVE BEEN ANSWERED TO MY SATISFACTION.

☐ I ACKNOWLEDGE THAT I HAVE HAD TIME TO CONSIDER HAVING THIS TREATMENT/PROCEDURE AND I AM MAKING A VOLUNTARY DECISION IN MY BEST INTEREST TO PROCEED WITH THE COVID-19 VACCINE, AND I HAVE CROSSED OUT ANY STATEMENTS THAT I DO NOT AGREE WITH.

_____ _____

Recipient/Surrogate/Guardian (Signature) Date / Time /Print Name/ Relationship to patient

_____ _____

Interpreter's Signature Date / Time / Language Interpreted

Please report all adverse reactions to COVID-19 monitoring hotline number:
718-250- RASH
(718-250-7274)

Area Below to be completed by the Vaccinator				
Which vaccine is the patient receiving today?				
Vaccine Name	Administration		EUA Fact Sheet Date	Manufacturer & Lot
Pfizer/BioNtech	☐ First	☐ Second		
Moderna	☐ First	☐ Second		
Astra-Zeneca	☐ First	☐ Second		
Janssen	☐ First	☐ Second		

Administration Site
☐ Left Deltoid ☐ Right Deltoid

Dosage:
0.3 ml

☐ I have reviewed side effects with patient.
☐ I confirm that the patient was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and or/their surrogate) have been answered correctly and to the best of my ability.

_____

Vaccinator Signature /Date /Time