COVID-19 Vaccination Program Guidance

Priority Groups Eligible to be Vaccinated

All individuals age 16 and older, who live, work, or study in New York are eligible to receive a COVID-19 vaccine. However, minors ages 16 and 17 are NOT authorized to receive the Janssen or Moderna COVID-19 Vaccines. Individuals under 16 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 16 or 17 years to provide in-person consent for vaccination at each dose.

Vaccine Support/Medical Documentation Staff must document in the CDMS 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 ID (school ID, learning permit, social security card, passport, etc.) with them.

COVID-19 Immunization Screening and Consent Form

Recipient Name (please print)			Preferred Name
DOB	Legal Gender	Gender ID	Marital Status **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	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	
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 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
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 treatments?	☐ 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

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. 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. 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 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 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.

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

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Telephonic Interpreter's ID # Date / Time

OR

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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 Number
Pfizer/ BioNTech	□ First Dose	□ Second Dose		
Moderna	□ First Dose	□ Second Dose		
Astra-Zeneca	□ First Dose	□ Second Dose		
Janssen	□ Single Dose			

Administration Site □ Left Deltoid □ Right Deltoid □ Left Thigh □ Right Thigh □ Nasal

Dosage □ 0.5 ml □ 0.25ml □ 0.3ml

□ I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable)

□ I confirm that the patient (and their surrogate, if applicable) 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 myability.

Vaccinator Signature: ____

May 1, 2021