Department of Education

Christopher Groll
Acting Assistant Commissioner,
Office of School Health
Tweed Courthouse
52 Chambers Street
New York, NY 10007

Chè fanmi,

Kòm ou ka konnen, tout Nouyòkè ki gen laj 12 ane pou pi piti ka kounye a resevwa yon vaksen COVID-19 gratis. Sa se yon trèbon nouvèl pou sante ak sekirite pitit ou, fanmi ou, kominote lekòl ou a, ak tout vil la!

An patenarya avèk NYC Test & Trace Corps ak Depatman Sante ak Ijyèn Mantal NYC, kèk lokal lekòl ap ofri vaksen Pfizer-BioNTech bay Nouyòkè ki elijib pandan premye semèn lekòl la (epi dezyèm dòz la nan kòmansman mwa oktòb la) pou fè li pi fasil posib pou w rete ansante. Li pa nesesè pou gen randevou, epi ou ka jwenn enfòmasyon sou lè lokal sa yo ap fonksyone nan lekòl ou a oswa si w ale nan schools.nyc.gov/covid19.

Pa gen danje pou pitit ou a pran vaksen an, sa konfidansyèl ak fasil. Men sa ou bezwen konnen:

- Ou pap bezwen bay prèv kondisyon imigrasyon ni yon nimewo sekirite sosyal pou pran vaksen an.
- Ou pa bezwen asirans sante pou pran vaksen an—vaksen an gratis.
- **Pou tout moun ki poko gen laj 18 ane, yon paran oswa responsab legal dwe bay konsantman. Nou mete yon fòm konsantman ansanm avèk lèt sa a pou ranpli epi voye l tounen.**
- Anplis, nou rekòmande— byenke sa pa obligatwa— pou tout elèv ki gen laj 12 ane rive 15 ane vini avèk yon paran oswa yon responsab nan lokal vaksinasyon an, oswa yon lòt moun paran an oswa responsab legal la nonmen pou reprezante l. Kit wi oswa non ou te chwazi akonpaye pitit ou a, yon pwofesyonèl medikal ki antrene nan lokal vaksen an ap kontwole pitit ou a pou 15 minit apre li fin pran vaksen an.
- Yo kenbe tout dosye ak enfòmasyon ki asosye avèk vaksinasyon yo estrikteman konfidansyèl.
- Se pwofesyonèl medikal ki resevwa fòmasyon ki bay vaksen yo.
- Entèpretasyon nan telefòn nan plizyè lang ap disponib sou plas.
- Byenke nou rekòmande sa seryezman, vaksinasyon pa obligatwa kounye a pou pifò elèv. Li obligatwa pou elèv k ap patisipe nan espò Lig atlèt lekòl leta (Public School Athletic League, PSAL) ke yo konsidere ki gen gwo risk posib pou transmisyon COVID-19. (Pou jwenn plis enfòmasyon, ale sou: schools.nyc.gov/PSAL).
- Vaksinasyon nan tout vil la deja redui yon fason dramatikman pousantaj ka pozitif COVID-19, sa ki ede vil la rekòmanse fonksyone, retabli rasanbleman anpèsòn, ak amelyore kalite lavi tout moun.

(kontinye nan paj 2)

- Yo ankouraje fanmi pou anrejistre kondisyon vaksinasyon elèv yo nan Pòtal Vaksinasyon COVID-19 DOE a nan: https://vaccine.schools.nyc. Lè w bay enfòmasyon sa yo, sa pral ede repons ak efò rekiperasyon Vil Nouyòk pote nan pandemi an, epi sa ap ede asire lekòl ak bilding DOE yo rete san danje pou tout elèv ak estaf yo.

Si w gen nenpòt kesyon, ale nan nyc.gov/covidvaccine pou wè tout fè yo. Nou priye w anpil pou pa tann pou fè pitit ou a pran vaksen an.

Avèk senserite,

Christopher Groll

Christopher Groll
Asistan Komisè pa Enterim
Biwo Sante Lekòl
Divizyon Klima ak Sante Lekòl
Depatman Edikasyon Vil Nouyòk

New York State Department of Health
Bureau of Immunization

COVID-19 Immunization Screening and Consent Form*

Recipient Name (please print)		Preferred Name
DOB	Current Gender ID Indicate ID Below: ☐	**Key:** W – Woman/Girl TW – Transgender Woman/Girl M – Man/Boy TM – Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming Q – Not Sure/Questioning NR – Chose not to Respond GNL - Gender not Listed (write-in) * Gender Pronouns: write-in by client's name
Sex Assigned at Birth Indicate Sex Below: ☐	**Key:** M – Male F – Female I – Intersex NR – Chose not to Respond	Marital Status Indicate Status Below: ☐	**Key:** S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner
Address City State Zip		Email Address	
Parent/Guardian/ Surrogate (if applicable, please print)		Phone	Preferred Language
Ethnicity Indicate Ethnicity Below: ☐	**Ethnicity Key:** DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK - Unknown	Race Indicate Race Below: ☐	**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

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 feeling sick today?	☐ Yes	☐ No	
2.	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 or quarantine at home due to COVID-19 infection or exposure?	☐ Yes	☐ No	☐ Unknown
3.	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
4.	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
5.	Are you pregnant or considering becoming pregnant?	☐ Yes	☐ No	☐ Unknown

6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	□ Yes	□ No	□ Unknown
7.	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
8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	□ Yes	□ No	□ Unknown
10.	Have you received a previous dose of the Pfizer, Moderna or Janssen COVID-19 vaccine?	□ Yes	□ No	Date: _____ (if applicable)
11.	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)?	□ Yes	□ No	Date: _____ (if applicable)

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 my vaccine requires two doses, I 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 asdescribed.

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 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

Dosage □ 0.5 ml □ 0.3 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 July 12, 2021**