Department of Education

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

가족 여러분께,

아시는 바와 같이 모든 12 세 이상 뉴욕 주민들은 COVID-19 백신을 접종 받을 수 있습니다. 이것은 여러분의 자녀, 가정, 학교 커뮤니티, 뉴욕시 전체의 건강과 안전을 위해 좋은 소식입니다.

NYC Test & Trace Corps 및 NYC 보건정신위생부가 협력하여 일부 학교에서 개학 첫 주 동안(2 차 접종은 10 월에 시작될 것입니다) 자격을 갖춘 뉴욕 주민들이 쉽고 안전하게 Pfizer-BioNTech(화이자) 백신 접종을 받을 수 있도록 제공할 것입니다. 예약하실 필요가 없으며 귀하의 학교 또는 다음 웹사이트를 방문하여 백신 접종 장소 및 시간에 대해 알아보시기 바랍니다: schools.nyc.gov/covid19.

자녀분의 접종은 안전하고 비밀이 보장되며 간단합니다. 상세 내용은 다음과 같습니다:

- 접종을 위해 체류 상태 증명이나 사회보장번호는 필요 없습니다.
- 백신 접종을 위해 의료 보험도 필요 없습니다- 백신은 무료 입니다.
- **18 세 이하는 부모님이나 법적 보호자가 동의해야 합니다. 이 통지문에 작성하여 제출해주셔야 할 동의서를 첨부하였습니다.**
- 추가적으로 의무 사항은 아니지만 12-15 세 학생은 학부모나 보호자 또는 학부모/보호자가 지정한 성인이 백신 접종 사이트에 동반할 것을 추천합니다. 자녀분과 함께 오시던 오시지 않으시던 자녀분은 백신 접종을 마친 후 15 분 동안 백신을 접종한 곳에서 훈련 받은 의료 전문가의 감독을 받게 될 것입니다.
- 백신 관련 모든 기록 및 정보는 비밀이 보장됩니다.
- 백신은 훈련받은 의료 전문가가 투여합니다.
- 현장에서는 다양한 언어로 전화 통역을 제공합니다.
- 강력히 추천하지만, 백신 접종이 대부분의 학생들에게 현재 의무 사항은 아닙니다. 예외는 잠재적으로 COVID-19 전염 위험이 높은 것으로 고려되는 공립학교 체육리그(PSAL)에 참여하는 학생들입니다. (자세한 정보 검색: schools.nyc.gov/PSAL).
- 뉴욕시 차원의 백신 접종을 통해 뉴욕시의 COVID-19 확진률이 급격히 줄어들었으며, 뉴욕시를 다시 개방하고, 대면 활동이 재개되어, 모든 사람들의 삶의 질이 개선되었습니다

(2 페이지에 계속)

- 가정에서 학생의 백신접종 상태를 교육청의 COVID-19 백신접종 포탈에 기록해 주실 것을 부탁 드립니다: https://vaccine.schools.nyc. 이 정보를 제출하는 것은 뉴욕시의 전염병 대응 및 회복 노력을 지원하고 교육청 학교들 및 건물이 모든 학생과 직원을 위한 안전한 곳으로 유지될 수 있도록 도와줄 것입니다.

모든 정보에 대한 질문이 있으시면 웹사이트 nyc.gov/covidvaccine 를 참고 하십시오. 빠른 시일 내 자녀분이 백신접종을 받기를 강력하게 추천합니다.

안녕히 계십시오

Christopher Groll

Christopher Groll
부커미셔너 대행
학교 보건 담당실
학교 환경 및 웰니스 담당부
뉴욕시 교육청

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**