

COVID-19 VACCINATION PROGRAM GUIDANCE

Priority Groups Eligible to be Vaccinated

All individuals age 12 and older are eligible to receive a Pfizer COVID-19 vaccine. However, minors ages 12 to 17 are NOT authorized to receive the Janssen or Moderna COVID-19 Vaccines. Individuals under 12 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 12 to 17 years to provide in-person consent for vaccination at each dose.

Vaccine Support/Medical Documentation Staff must document in the CDMS/Microsoft 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 Jefferson County Public Health Service COVID-19 Immunization Screening and Consent form may be considered for this purpose.

Jefferson County Public Health Service 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 date of birth (birth certificate, passport, learning permit/driver's license, benefits card, etc.) *and* photo ID (passport, learning permit/driver's license, school ID, etc.)



Jefferson County PUBLIC HEALTH SERVICE

Public Health Facility, 531 Meade Street, Watertown, New York 13601

COVID-19 Immunization Consent and Screening Form

Recipient Name			
First	Middle	Last	
Date of Birth (MM/DD/YYYY) _____ / _____ / _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Race <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Multiracial <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> No Response		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> No Response	
Address		City	State Zip Code
Parent/Guardian/Surrogate Name		Relationship	
Phone (XXX-XXX-XXXX)		Email	
Screening Questionnaire			
1.	Is the recipient feeling sick today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
2.	In the last 10 days, has the recipient 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
3.	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? Date of last dose: _____ / _____ / _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
4.	Has the recipient ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot or severe allergic reaction (anaphylaxis) to anything?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown

5.	Is the recipient pregnant or considering becoming pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
6.	Does the recipient have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
7.	Does the recipient take any medications that affect his/her immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or has had any radiation treatments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
8.	Does the recipient have a bleeding disorder or is taking a blood thinner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
9.	Has the recipient received a previous dose of the COVID-19 vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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 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 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.

Recipient Parent/Surrogate/Guardian (Signature) Date/Time

Print Name Relationship to patient, if other than recipient

OR

Telephonic interpreter’s ID # Date/Time

OR

Signature: Interpreter Date/Time

Print: Interpreter’s Name Relationship to patient