ST. JOHN'S UNIVERSITY

COVID-19 Vaccination Consent Form

	Today's Date: _____/_____/_____
First Name: _____	Last Name: _____

Email: _____	Phone: _____	Preferred Language: _____

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer not to answer	Ethnicity: ☐ HIS – Hispanic Origin ☐ NHL – Non-Hispanic Origin ☐ UNK – Unknown ☐ DECL – Declined

Race:

☐ AIA – Native American or Alaskan
☐ BAA – African American or Black
☐ NHP – Native Hawaiian or Pacific Islander
☐ DECL – Declined
☐ ASN Asian
☐ WHT – White
☐ OTH – Other or Multiracial

Your Address: _____ _____ City State Zip Code	Parent/Guardian/Emergency Contact: _____ Parent/Guardian/Emergency Contact Phone Number: _____

Have you received a dose of the COVID vaccine in the past? ☐ No ☐ Yes,

Date of Vaccine: _____/_____/_____

If yes, which vaccine did you receive? ☐ Pfizer ☐ Moderna ☐ Johnson and Johnson

Clinic/Office Site Where Vaccine is Administered:

St. John's University

8000 Utopia Parkway, Queens NY 11439

Screening Questionnaire				
		YES	NO	Unknown
1.	Are you feeling sick today?			
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?			
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?			
4.	Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?			
5.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot+?			
6.	Are you pregnant or considering becoming pregnant?			
7.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?			
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?			
9.	I am 18 years of age or older			

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.

☐ New York State requires all Individuals being vaccinated to complete the New York State Vaccine form (forms.ny.gov/s3/vaccine). I am confirming that I have submitted the required New York State Vaccine form and I am attest that I am eligible to receive a COVID-19 vaccine.

Consent (Please check all the boxes affirming each statement)

☐ 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.

☐ I certify that I am: (I) the Patient and at least 18 years of age; (II) the parent or legal guardian of the minor as required by state law; or (III) the legal guardian of the Patient. Further, I hereby give my consent to the health care provider indicated below to administer the vaccine(s) I have requested.

☐ I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive.

☐ On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the health care provider identified below, his/her employer and associated staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees, including but not limited to St. John's University New York and its affiliated companies, from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above.

By signing below, I give St. John's University permission to vaccinate me for COVID-19 with the Pfizer vaccine. I also give St. John's permission to release my name and date of immunization to the NY State and NYC Immunization Registry as well as the NYC DOHMH

Print Name:_____	
Signature: _____	Date: _____/_____/_____