Department of Education

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

Dear Families,

As you might be aware, all New Yorkers aged 12 and older can now receive a free COVID-19 vaccine. This is great news for the health and safety of your child, your family, your school community, and the whole city!

In partnership with the NYC Test & Trace Corps and the NYC Department of Health and Mental Hygiene, some school sites are offering Pfizer-BioNTech vaccinations to eligible New Yorkers during the first week of school (with second doses provided at the beginning of October) to make it as easy as possible to stay safe. No appointment is needed, and you can learn more about site hours from your school or by visiting schools.nyc.gov/covid19.

Getting your child vaccinated is safe, confidential, and easy. Here's what you need to know:

- You will not need to provide proof of immigration status or a social security number to get vaccinated.
- You do not need health insurance to get vaccinated—the vaccine is free.
- **For all individuals under 18, a parent or legal guardian must provide consent. A Consent Form for you to complete and return is enclosed with this letter.**
- In addition, it is recommended— though not required— that students aged 12 to 15 be accompanied to the vaccination site by a parent or guardian, or another adult caregiver designated by the parent or guardian. Whether or not you chose to accompany your child, your child will be monitored by a trained medical professional at the vaccine site for 15 minutes following vaccine administration.
- All records and information associated with vaccination are kept strictly confidential.
- Vaccines are administered by trained medical professionals.
- On-site telephone interpretation in multiple languages will be available.
- While strongly recommended, vaccinations are not currently mandatory for most students. The exceptions are students participating in Public Schools Athletic League (PSAL) sports who are considered high-risk for potential COVID-19 transmission. (For more information, visit: schools.nyc.gov/PSAL).
- Citywide vaccinations have already dramatically reduced COVID-19 positivity rates, helping to reopen the city, restore in-person gathering, and improve everyone's quality of life.

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- Families are encouraged to record their student's vaccination status in the DOE's COVID-19 Vaccination Portal at: https://vaccine.schools.nyc. Submitting this information will support New York City's pandemic response and recovery efforts, and help ensure that DOE schools and buildings remain safe places for all students and staff.

If you have any questions, visit nyc.gov/covidvaccine for all the facts. We strongly urge you to get your child vaccinated soon.

Sincerely,

Christopher Groll

Christopher Groll
Acting Assistant Commissioner
Office of School Health
Division of School Climate & Wellness
NYC Department of Education

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**