IMMUNIZATION DOCUMENTATION AND CONSENT FORM

Name:_____ DOB:_____Gender:_____

Address:_____

_____

Phone Number:_____Email Address:_____

Primary Care Physician:_____ PCP's Phone Number:_____

Please select the vaccine you would like to receive:

☐ Influenza (FLU) ☐ COVID-19 (MODERNA) ☐ Other_____

Eligibility Attestment for COVID-19 vaccine (SELECT ONE OPTION ONLY):

☐ I am **65 years or older* (WRITE AGE CLEARLY):_____**

☐ I am **12–64 years old and have at least one medical condition*** that increases my risk of severe COVID-19 (examples: diabetes, heart disease, lung disease, weakened immune system, obesity, etc.) - see posted list for all conditions

☐ I am **under 65 with no underlying conditions**

IMMUNIZATION SCREENING QUESTIONNAIRE

Do you feel sick or unwell today?	Y	N
Do you have any allergy to latex or vaccine components?	Y	N
Have you ever had a serious reaction (ie. anaphylaxis) after getting a vaccine?	Y	N
Do you have a lung, heart, kidney, or metabolic disease? If yes, please list:_____	Y	N
Do you have a seizure or brain disorder, Guillain-Barre Syndrome, nervous system disorder, or Multisystem Inflammatory Syndrome (MIS-A or MIS-C)?	Y	N
Do you have a weakened immune? (Active cancer, HIV/AIDS, transplant, or other condition?	Y	N
Do you have history of myocarditis or pericarditis?	Y	N
It has been > 3 months since my last COVID vaccine or having COVID	Y	N

I consent to allow the provider to administer the above-listed immunization(s). I understand that the provider will upload this information to the New York State Immunization Information System (NYSIIS) and that it may be accessible to other healthcare providers. I agree to pay for any financial responsibility associated with the above-listed immunization at the time of receiving the service. I acknowledge that insurance coverage is not guaranteed, and if my insurance plan denies or later reverses payment for this immunization, I am responsible for the full cost. I also understand that this provider is not responsible for any side effects or harm caused by my receiving this immunization.

*I am aware mNEXSPIKE will be administered for individuals over 65 when available, and all other eligible individuals will receive SPIKEVAX

Signature:_____ Date:_____

175 S Riverside Ave | Croton-on-Hudson, NY 105201 | T: 914-271-2900 F: 914-271-3539

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Vaccine Administered	Site of Administration	Lot/Sticker	Exp. Date	VIS date
INFLUENZA (FLU)	☐ **Left Deltoid** ☐ **Right Deltoid**			
COVID 19 (SPIKEVAX)	☐ **Left Deltoid** ☐ **Right Deltoid**			
COVID 19 (mNEXSPIKE)*	☐ **Left Deltoid** ☐ **Right Deltoid**			
NOT ELIGIBLE FOR COVID				

Place Rx Label(s) Here

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STAMP HERE

Immunizer Signature:_____Date:_____

Immunizer Initials:_____

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LAST UPDATED 9/17/25