NYS Veterans Home at Batavia

Staff COVID-19 2025-2026 Consent Form

Name **Date of Birth** **Phone #**

Address **City** **State** **Zip**

Health Insurance Carrier and Policy #

Are you currently sick with a fever?	**Y**	**N**
Do you have any allergies to medications, food, a vaccine component or latex?	**Y**	**N**
Have you ever had a serious reaction after receiving a vaccine?	**Y**	**N**
Have you ever had a COVID-19 vaccine?	**Y**	**N**
Are you a smoker or have any chronic medical conditions such as heart, lung, kidney or metabolic disease?	**Y**	**N**
Do you have any conditions such as cancer, HIV/AIDS or take any medications such as steroids or anticancer drugs that affect your immune system?	**Y**	**N**
Have you ever been diagnosed with a heart condition or have you had Multisystem Inflammatory Syndrome after a COVID-19 infection?	**Y**	**N**
In the past year, have you received any immune globulin, blood/blood products or an antiviral drug?	**Y**	**N**
Are you pregnant?	**Y**	**N**
Have you received any other vaccinations in the past 4 weeks?	**Y**	**N**

If yes, please describe:_____

If yes, please describe:_____

☐ I consent to receive the COVID-19 2025-2026 vaccination. I have read or had explained to me the Vaccine Information Statement about the COVID-19 vaccine. I have had a chance to ask questions, which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I authorize release of any medical or other information necessary to process an insurance claim or for other public health purpose.

☐ I decline to receive the COVID-19 2025-2026 vaccination

Signature_____ **Date**_____

To be completed by administering nurse:

Date Vaccine Administered_____ Date VIS (01/2025) Given_____

Manufacturer/dose (circle one): Moderna 0.5mL/0.2mL Pfizer 0.1mL
Lot/Expiration_____

Injection Site_____ Administered by_____