

NYS Veterans Home at Batavia
Staff COVID-19 2026-2027 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
If yes, please describe: _____		
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
If yes, please describe: _____		
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

☐ I consent to receive the COVID-19 2026-2027 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 2026-2027 vaccination

Signature _____ **Date** _____

To be completed by administering nurse:

Date Vaccine Administered _____

Date VIS Given _____

Manufacturer/dose: Moderna 0.5mL

Lot/Expiration _____

Injection Site _____

Administered by _____