**Consent form**

for administration of the COVID 19 vaccine

Please fill with block capitals

|  |  |
| --- | --- |
| **Name:** |  |
| **Date of birth:** |  |
| **TAJ number:** |  |
| **Address:** |  |
| **Phone number:** |  |
| **e-mail address:** |  |

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Do you have any chronic illness? (diabetes, high blood pressure, asthma, heart disease, kidney disease) |  |  |
| If yes, please list them here: | | |
| Do you take medication regularly? |  |  |
| If yes, please list them here: | | |
| Do you have any allergies? (food, medication, other) |  |  |
| If yes, please list them here: | | |
| Have you ever fainted previously during a blood draw? |  |  |
| Did you ever have an anaphylactic reaction after vaccination? |  |  |
| Did you have any acute illness in the last 4 weeks? |  |  |
| Did you have fever in the last two weeks? |  |  |
| Do you have any surgeries planned in the next month? |  |  |
| Did you have any medical procedures perfomed on you lately? |  |  |
| |  | | --- | | Do you have any autoimmune disease that is currently in its active phase? | |  |  |
| |  | | --- | | Did you receive treatment weakening your immune system in the past 3 months? (e.g. cortisone, prednisone, other steroids, immunology products, anti-tumour products, irradiation) | |  |  |
| Did you ever have seizures, nervous system problems, and paralysation? |  |  |
| Do you have any blood disorders, or haemophilia? |  |  |
| Have you received any other vaccination in the past 4 weeks? |  |  |
| Do you have any symptoms right now? |  |  |
| If yes, please list them here: |  |  |
| Are you pregnant? |  |  |
| Are you planning a pregnancy in the next two months? |  |  |
| Are you breastfeeding? |  |  |

After receiving the vaccine, there might be allergic reactions, therefore I will stay at this location for ….. minutes after vaccination. If I leave before that, it will be on my own responsibility.

Date: ……………………………………………..

……………………………………………

Signature

The patient left on…………………………, 2021, at …………………………….. (hour/minute), after observation, without experiencing any side effects. They have agreed to aftercare.