CONSENT FORM

for vaccination against COVID-19 disease

Name: Date of Birth:
Social Security Number: Address:
Phone Number: E-mail address:

PLEASE, ANSWER THE FOLLOWING QUESTIONS! (Mark with „X")

	Yes	No
Do you have a chronic condition (e.g.: diabetes, high blood pressure, asthma, heart or kidney disease, etc.)?		
Do you take medicine regularly?		
Are you allergic to something (food, medicine, other)?		
Have you ever felt sick during vaccination or blood collection?		
After vaccination, have you ever had an anaphylactic reaction? **(Note: anaphylactic shock for unknown medicine means exclusion from vaccination; allergy to febrifuge or antibiotics does not.)**		
Did you have any kind of acute disease in the past 4 weeks?		
Did you have a fever in the past 2 weeks? **(Note: acute fever or a positive PCR test from the past 3 months mean exclusion from vaccination at the moment.)**		
Are you suffering from any active autoimmune diseases?		
Did you receive any treatment, which impaired your immune system in the past 3 months, such as: cortisone, prednisone, other steroids, immunobiological or anti-cancer products, or radiotherapy?		
Have you ever experienced seizures, nervous system disorders or paralysis?		
Are you suffering from haematopoietic disease or haemophilia?		
Did you receive any vaccine in the past 2 weeks?		
Do you have any complaints?		
Are you pregnant?		
Are you planning to be pregnant in 2 months?		
Are you lactating?		

Date:…….

……..
Signature