COVID-19 Vaccination consent form

Name:
Date of Birth:
Social security number:

Address:
Telephone number:
E-mail address:

PLEASE ANSWER THE QUESTIONS BELOW!

	Yes	No
Do you have a chronic disease? (diabetes, high blood pressure, asthma, heart- kidney disease etc.):		
Do you take any medications regularly?		
Do you have any allergies (food, medication, other)?		
Have you ever been sick after immunization or giving a blood sample?		
Have you ever had an anaphylactic reaction after getting vaccinated? (Important: Anaphylaxis caused by an unknown medication is ground for exclusion, while antibiotics- and antipyretic allergies are NOT!		
Have you had any acute diseases the past 4 weeks?		
Have you had fever the past 2 weeks? (Important: acute febrile disease, PCR confirmed infection within 3 months are grounds for exclusion)		
Do you have an autoimmune disease that is currently in its active phase?		
Have you received any treatment that weakened your immune system in the past 3 months? For example: cortisone, prednisone, other steroids, immunobiological or anti-tumour products, or radiation treatment?		
Have you ever had seizures, problems with your nervous system, or paralysis?		
Do you have any blood disorders or haemophilia?		
Have you been vaccinated the past 2 weeks?		
Do you have any health complaints right now?		
Are you pregnant?		
Do you plan to get pregnant within the next 2 months?		
Are you breastfeeding?		

Date: ....

Signature