Consent form for the influenza vaccination

The answers to the following questions concerning your medical history are required for your scheduled vaccination appointment. It is therefore in your own interest to provide accurate and complete information. All provided information is protected by medical confidentiality.

Please write clearly and check the appropriate boxes.

Last name, first name, date of birth	
Employer	

1. Have you received an influenza vaccination in the past? yes ☐ no ☐

If so, when? _____

2. Have you ever experienced any health-related problems, especially allergic reactions (rashes, shortness of breath, swollen face or tongue), either during or after any previous vaccinations? yes ☐ no ☐

If so, please describe your symptoms: _____

_____

3. Do you suffer from any allergies or hypersensitivity, especially to chicken protein? yes ☐ no ☐

If so, please specify: _____

4. Are you currently receiving allergen immunotherapy? yes ☐ no ☐

5. Have you suffered from any acute and feverish disease in recent days/weeks? yes ☐ no ☐

If so, please specify: _____

6. Do you take any medication on a regular basis? yes ☐ no ☐

If so, please specify: _____

7. Are you currently pregnant? yes ☐ no ☐

☐ **I have read the information about the vaccination against influenza thoroughly and have had the opportunity to clarify any questions in conversation with the doctor and to obtain further information from them**.

☐ **I have no further questions and would like to be vaccinated against influenza.**

_____ _____

Place and date Signature of the vaccinated person

Documentation

Vaccine and batch	Date of vaccination	Doctor's signature