STATEMENT OF CONSENT

For the administration of COVID-19 vaccine

Name: Date of birth:
No. of passport: Address:
Phone number: email address:

PLEASE ANSWER THE FOLLOWING QUESTIONS! (Check all that apply)

	Yes	No
Do you have any chronic illness? (diabetes, high blood pressure, asthma, heart disease, kidney disease, etc.):		
Do you take medicine regularly?		
Do you have any allergies (food, medicine, other)?		
Have you previously had a malaise during blood draws or vaccinations?		
Did you have an anaphylactic reaction after administration of any vaccine? **(Note: unknown drug-induced anaphylaxis exclusion criteria, antibiotic allergy, antipyretic allergy NO!)**		
Have you had any acute illness in the last 4 weeks?		
Have you had a febrile illness in the last 2 weeks? **(Note: Acute febrile illness exclusion criteria)**		
Do you have an autoimmune disease that is in active phase?		
In the last 3 months, have you received any treatment that weakens your immune system, such as: cortisone, prednisone, other steroids, immunobiologicals or anti-tumor medicines, or radiotherapy?		
Have you ever had a seizure, nervous system problem, paralysis?		
Do you suffer from hematopoietic disease, or haemophilia?		
Have you been vaccinated in the last 2 weeks?		
Do you currently have any symptom?		
Are you pregnant?		
Are you planning to become pregnant within 2 months?		
Are you currently breastfeeding?		

Date:……

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Signature