

PFIZER-BIONTECH COVID-19 **MODERNA COVID-19** **VAXZEVRIA COVID-19** **JANSSEN**

Full name (first name and surname) _____

Date of birth _____ Place of birth _____

Home address _____ Phone _____

Health Insurance Card (if available) n. _____

I have read, I have been informed in a language I speak and I have fully understood the fact sheet drafted by the Italian Medicines Agency (Agenzia Italiana del Farmaco, AIFA) regarding the vaccine indicated above.

I have informed the doctor about any current and/or past pathology and ongoing treatment.

I have had the opportunity to ask questions about the vaccine and my health status, which were answered to my satisfaction and in a comprehensible way.

I have been informed correctly and clearly. I have understood the risks and benefits of the vaccine, its modalities and therapeutic alternatives, and the consequences of a possible withdrawal or refusal to complete the vaccination with the second dose, if needed.

I am aware that, in case of side effects, it is my responsibility to inform my doctor immediately and to follow his recommendations.

I consent to stay in the waiting room for at least 15 minutes after the vaccine administration, in order to make sure that no immediate side effects occur.

I CONSENT AND AUTHORIZE the administration of the vaccine indicated above

Place and date _____

Signature of the person who is receiving the vaccine or his/her legal decision maker _____

I DO NOT CONSENT the administration of the vaccine indicated above

Place and date _____

Signature of the person who is receiving the vaccine or his/her legal decision maker _____

HEALTHCARE PROFESSIONALS WHO ADMINSTRATED THE VACCINE

1. First name and surname _____

Role _____

I confirm that the patient gave his/her consent to receive the vaccine, after being adequately informed.

Signature _____

2. First name and surname _____

Role _____

I confirm that the patient gave his/her consent to receive the vaccine, after being adequately informed.

Signature _____

The presence of a second healthcare professional is not necessary if the vaccination is administered at a doctor's office or in other settings where just one doctor is operating, and in case of home vaccinations or logistic and organizational problems.

MEDICAL HISTORY SHEET

Patients must fill in the form and revise it together with healthcare professionals enrolled as vaccination providers.

First name and surname	Phone		
MEDICAL HISTORY	YES	NO	DON'T KNOW
Are you feeling ill?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies to latex, food, drugs or to any component of this vaccine? If YES, please describe _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious reaction following any vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from heart or lung diseases, asthma, kidney diseases, diabetes, anaemia or other blood diseases?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your immune system compromised (e.g., cancer, leukaemia, lymphoma, HIV/AIDS, transplant)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last three months, have you been taking immunodepressive drugs (e.g., cortisone, prednisone or other steroids) or anticancer drugs, or have you been undergoing radiation therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last year, have you received any blood or blood components transfusions, or have you been taking immunoglobulins (IgG) or antiviral drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had convulsions or have you ever suffered from any brain or nervous system conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you received any other vaccination in the last 4 weeks? If YES, please describe _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For women: are you pregnant or planning to become pregnant in the month following the first or the second dose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please specify any drugs, especially anticoagulant drugs, natural supplements, vitamins, minerals or alternative medicines you are currently taking: _____

COVID-RELATED MEDICAL HISTORY	YES	NO	DON'T KNOW
In the last month, have you been in contact with anyone infected with Sars-CoV2 or suffering from COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:			
• Cough/ cold/ fever/ dyspnoea or other flu-like symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sore throat/loss of smell or taste?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Abdominal pain/diarrhoea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Abnormal bruising or bleeding/ red eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Have you travelled abroad in the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COVID-19 TEST:			
• No recent COVID-19 tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Negative COVID-19 test results (date _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Positive COVID-19 test results (date _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Waiting for COVID-19 test results (date _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please specify any pathologies or useful information about your health status _____

Place and date _____

Signature of the person who is receiving the vaccine or his/her legal decision maker _____