ANTI-COVID-19 VACCINATON

CONSENT FORM

Name and Surname: ……	
Date of birth: ……	Place of birth: ……
Residence: …… ……	Telephone: …… . …… .
National Health Service Card (if available): N. ……	

I have read, I have received in a language known to me, and I have completely understood the General Information drafted by the Italian Medicines Agency (AIFA) regarding the

"_____" vaccine.

I have informed the doctor of all diseases, current and/ or past, and any treatment I am currently on.

I have had the opportunity to ask questions concerning the vaccine and regarding my health status, and I have received comprehensive answers, which I have understood.

I have been correctly informed, with words that are clear to me. I have understood the benefits and the risks of the vaccination, how it is performed, and any therapeutic alternatives as well as the consequences should I refuse or forgo completing the vaccination with the second dose, if required.

I am aware that, should any side effect occur, it is my responsibility to inform my doctor immediately and to follow the instructions provided.

I accept to remain in the waiting room for at least 15 minutes after the vaccine is administered to ensure that no immediate side effect occurs.

I consent to and authorize the administration of the "_____"vaccine.

Date and place _____

Signature of the person who is receiving the vaccine or of his/ her legal representative

_____

I refuse administration of the "_____" vaccine.

Date and place _____

Signature of the person who is refusing the vaccine or of his/ her legal representative

_____

Health care workers of the vaccination team

1. Name and surname (Doctor)_____
I confirm that the vaccine recipient has expressed his/ her consent to the vaccine,after having been adequately informed.
Signature _____

2.Name and surname (Doctor or other health care worker)

_____

Role _____

I confirm that the vaccine recipient has expressed his/ her consent to the vaccine,after having been adequately informed.

Signature _____

The presence of a second health care worker is not indispensable when the vaccine is administered at a doctor's office or center, at the recipient's home, or in the event of a logistical/ organizational crisis.

Attachment 2

Attached to the Consent form

SARS-CoV-2/COVID-19 VACCINATION

To be completed by the vaccine recipient and reviewed with the vaccination health care professionals

First name and surname: ……. *Nome e cognome: …… ……* **Date and place of birth:** …… *Data e luogo di nascita:* ……	**Telephone:** *Telefono:* ……..		
MEDICAL HISTORY *ANAMNESI*	***YES*** *SI*	***NO*** *NO*	***Don't know*** *Non so*
Are you currently sick? *Attualmente è malato?*			
Do you have a high temperature? *Ha febbre?*			
Are you allergic to latex, any food, medicines or any of the vaccine ingredients? If yes, please specify: …… *Soffre di allergie al lattice, a qualche cibo, a farmaci o ai componenti del vaccino? Se sì specificare: ……*			
Have you ever had a serious reaction after receiving a vaccine? *Ha mai avuto una reazione grave dopo aver ricevuto un vaccino?*			

Do you suffer from heart or lung disease, asthma, kidney disease, diabetes, anaemia or other blood disorders? *Soffre di malattie cardiache o polmonari, asma, malattie renali, diabete, anemia o altre malattie del sangue?*			
Are you immunosuppressed? *(e.g. cancer, leukaemia, lymphoma, HIV/AIDS, transplant)* *Si trova in una condizione di compromissione del sistema immunitario? (Esempio: cancro, leucemia, linfoma, HIV/AIDS, trapianto)*			
In the last 3 months, have you taken any medicine that affects your immune system *(e.g. cortisone, prednisone or other steroids)* or anti-cancer drugs, or have you undergone radiation treatment? *Negli ultimi 3 mesi, ha assunto farmaci che indeboliscono il sistema immunitario* *(esempio: cortisone, prednisone o altri steroidi) o farmaci antitumorali, oppure ha subito trattamenti con radiazioni?*			
Over the last year, have you received a blood transfusion or blood products, or have you been given immunoglobulins (gamma) or antiviral drugs? *Durante lo scorso anno, ha ricevuto una trasfusione di sangue o prodotti ematici, oppure le sono stati somministrati immunoglobuline (gamma) o farmaci antivirali?*			
Have you had any seizures or any problems with your brain or nervous system? *Ha avuto attacchi di convulsioni o qualche problema al cervello o al sistema nervoso?*			
Have you received any vaccinations in the last 4 weeks? If yes, which? *Ha ricevuto vaccinazioni nelle ultime 4 settimane? Se sì, quale/i?*			

Are you taking any anticoagulant medication? *Sta assumendo farmaci anticoagulanti?*			

FOR WOMEN ONLY: *PER LE DONNE:*	***YES*** *SI*	***NO*** *NO*	***Don't know*** *Non so*
Are you pregnant or are you considering getting pregnant in the month following the first or second dose? *è incinta o sta pensando di rimanere incinta nel mese successivo alla prima o alla seconda somministrazione?*			
Are you breast-feeding? *sta a lattando?*			
Specify below the medicines, as well as any natural supplements, vitamins, minerals or alternative medicines you are taking: Specifichi di seguito i farmaci, nonché gli integratori naturali, le vitamine, i minerali o eventuali medicinali alternativi che sta assumendo: …… ……..			
COVID-RELATED MEDICAL HISTORY *ANAMNESI COVID-CORRELATA*	***YES*** *SI*	***NO*** *NO*	***Don't know*** *on so*
In th last month, **<u>have</u>** you been in contact with a person infected with Sars- CoV2 or suffering from COVID-19? *Nell'ultimo <u>mese è</u> stato in contatto con u a persona contagiata da Sars-CoV2 o affetta da COVID-19?*			
Have you had any of the following symptoms: *Manifesta uno dei seguenti sintomi:*			
- Cough/cold/high temperature/breathlessness or flu-like symptoms? *Tosse/raffreddore/febbre/dispnea o sintomi similinfluenzali?*			
- Sore throat/loss of sense of smell or taste?			

Mal di gola/perdita dell'olfatto o del gusto?			
- Abdominal pain/diarrhoea? *Dolore addominale/diarrea?*			
- Abnormal bruising or bleeding/reddening of the eyes? *Lividi anormali o sanguinamento/arrossamento degli occhi?*			
- Have you travelled abroad in the last month? *Ha fatto qualche viaggio internazionale nell'ultimo mese?*			
COVID-19 TESTS *TEST COVID-19*			
No recent COVID-19 test *Nessun test COVID-19 recente* Negative COVID-19 test (Date:) *Test COVID-19 negativo (Data:)* Positive COVID-19 test (Date:) *Test COVID-19 positivo (Data)* Waiting for COVID-19 test (Date:) *In attesa di test COVID-19 (Data:)*			
Report any other conditions or useful information about your health: *Riferisca eventuali altre patologie o notizie utili su Suo stato di salute:* …… ……			