COVID-19 VACCINATION

CONSENT FORM (Third dose – booster dose)

Name and Surname: ……	
Date of birth: …….	Place of birth: ……..
Permanent address: …… ……	Phone: …… ……..
Health insurance card no. (if available) ……..	

I read, it was illustrated to me in a known language and I fully understood the Information Notice written by the Italian Medicines Agency (AIFA) about the vaccine: "_____"

I reported to the Doctor current and/or previous diseases and therapies in progress.

I had the opportunity to ask questions about the vaccine and my state of health, I obtained comprehensive answers and I understood them.

I was clearly informed and I understood the benefits and risks of vaccination, modalities and therapeutic alternatives, as well as consequences of a possible refusal or renunciation of completing the vaccination with the third dose (booster dose).

I am aware that if any side effect occurs, I am responsible for immediately informing my family doctor and for carrying out the instructions.

I agree to remain in the waiting room for at least 15 minutes after the vaccination in order to ensure that no immediate adverse reactions occur.

I consent and authorize the inoculation of the vaccine "_____".

Date and place _____

Signature of the vaccinee or Legal representative _____

I refuse the inoculation of the vaccine "_____"

Date and place _____

Signature of the vaccinee or Legal representative _____

Last update on 27 September 2021

Health professionals of the vaccination team

1. Name and Surname (Doctor)_____

I confirm that the vaccinee was adequately informed and has given his/herconsent to the vaccination.

Signature _____

2. Name and Surname (Doctor or other Healthcare Professional)

_____

Position _____

I confirm that the vaccinee was adequately informed and has given his/her consent to the vaccination.

Signature _____

The presence of the second Health Professional is not essential in the case of Vaccination in a clinic or other place with one Doctor only, at the home of the Vaccinee or in a difficult logistical-organizational situation.

Vaccination details

Lot no.	**Right**	**Left**
Date	**Signature of the Professional**	

COVID-19 VACCINATION

ANAMNESTIC SHEET

The vaccinee will fill in this form and review its content with the Health Professionals of the vaccination team.

Name and Surname:	Phone:		
Anamnesis	**YES**	**NO**	**I don't know**
Are you currently sick?			
Do you have a fever?			
Do you suffer from allergies to latex, food, drug or vaccine components? If yes, please specify:……..…… ……...			
Have you ever had a severe reaction after receiving a vaccine?			
Do you suffer from heart or lung disease, asthma, kidney disease, diabetes, anaemia or other blood disorders?			
Are you in a condition of compromised immune system? (for example: cancer, leukaemia, lymphoma, HIV/AIDS, transplant)?			
In the past 3 months, have you taken any medications that weaken the immune system (for example: cortisone, prednisone or other steroids) or anticancer drugs, or have you undergone radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, or have you been given immunoglobulins (gamma) or antiviral drugs?			
Have you had convulsion attack or any problems with your brain or nervous system?			
Have you received any vaccinations in the past 4 weeks? If yes, please specify:..... …….			
For women: - are you pregnant or are you planning to become pregnant in the month following the first or second dose of vaccine?			
- are you breastfeeding?			
Are you taking any blood thinner medication?			

Specify below the drugs, and **in particular those anticoagulants**, as well as natural supplements, vitamins, minerals or any alternative medicines you are taking:

_____

_____

_____

_____

_____

COVID-related anamnesis	YES	NO	I don't know
Have you been in contact with a person infected with Sars-CoV2 or affected by COVID-19 in the last month?			
You have any of the following symptoms:			
Cough/cold/fever/dyspnoea or flu-like symptoms?			
Sore throat/loss of smell or taste?			
Abdominal pain/diarrhoea?			
Abnormal bruising or bleeding/redness of the eyes?			
Have you made any international trip in the last month?			
COVID-19 testing: No recent COVID-19 testing COVID-19 testing negative (Date: _____ _____) COVID-19 testing positive (Date: _____ _____) Waiting for COVID-19 testing (Date: _____ _____)			

Date of the second dose of the vaccination _____

Report any other disease or useful information about your state of health

_____

_____

_____

_____

_____

_____

DATE AND PLACE

SIGNATURE

…… ……