Updated on 27 March 2021

COVID-19 VACCINATION

CONSENT FORM

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 second 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

_____

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.