SST Azienda USL Toscana centro
Servizio Sanitario della Toscana

# VACCINATION CONSENT FORM

☐ **PFIZER-BIONTECH COVID-19** ☐ **MODERNA COVID-19** ☐ **NUVAXOVID COVID-19**

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 _____

You can find more information about the treatment of personal data in accordance with article 13 and 14 of the EU Regulation 2016/679 at the following link:
https://www.uslcentro.toscana.it/index.php/privacy/privacy-in-azienda
Otherwise, you can scan the QR Code on the right.

Signature _____

HEALTHCARE PROFESSIONALS WHO ADMINISTRATED 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? | ☐ | ☐ | ☐ |
| Do you have a fever? | ☐ | ☐ | ☐ |
| Do you have any allergies to latex, food, drugs or to any component of this vaccine? If YES, please describe _____ | ☐ | ☐ | ☐ |
| Have you ever had a serious reaction following any vaccine? | ☐ | ☐ | ☐ |
| Do you suffer from heart or lung diseases, asthma, kidney diseases, diabetes, anaemia or other blood diseases? | ☐ | ☐ | ☐ |
| Is your immune system compromised (e.g., cancer, leukaemia, lymphoma, HIV/AIDS, transplant)? | ☐ | ☐ | ☐ |
| 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? | ☐ | ☐ | ☐ |
| In the last year, have you received any blood or blood components transfusions, or have you been taking immunoglobulins (IgG) or antiviral drugs? | ☐ | ☐ | ☐ |
| Have you ever had convulsions or have you ever suffered from any brain or nervous system conditions? | ☐ | ☐ | ☐ |
| Have you received any other vaccination in the last 4 weeks? If YES, please describe _____ | ☐ | ☐ | ☐ |
| **For women**: are you pregnant or planning to become pregnant in the month following the first or the second dose? | ☐ | ☐ | ☐ |
| Are you breastfeeding? | ☐ | ☐ | ☐ |

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? | ☐ | ☐ | ☐ |
| **DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:** | | | |
| • Cough/ cold/ fever/ dyspnoea or other flu-like symptoms? | ☐ | ☐ | ☐ |
| • Sore throat/loss of smell or taste? | ☐ | ☐ | ☐ |
| • Abdominal pain/diarrhoea? | ☐ | ☐ | ☐ |
| • Abnormal bruising or bleeding/ red eyes? | ☐ | ☐ | ☐ |
| • Have you travelled abroad in the last month? | ☐ | ☐ | ☐ |
| **COVID-19 TEST:**<br>• No recent COVID-19 tests<br>• Negative COVID-19 test results (date_____)<br>• Positive COVID-19 test results (date_____)<br>• Waiting for COVID-19 test results (date_____) | ☐ | ☐ | ☐ |

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 _____