STATEMENT OF APPROVAL

**Of the receipt of a vaccination against COVID-19 infection**

Name (Family name first): Date of birth:

TAJ number: Address:

Telephone number: e-mail address:

PLEASE, ANSWER THE FOLLOWING QUESTIONS! (Tick **all** appropriate answers.)

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Do you have a long-term, chronic illness? (diabetes, high blood pressure,  asthma, heart disease, kidney disease, etc.): |  |  |
| Do you take medicine regularly? |  |  |
| Do you have any allergies (food, medicine, other)? |  |  |
| Have you previously had a malaise during blood draws or vaccinations? |  |  |
| Did you have an anaphylactic reaction after receiving any vaccine? **(Note: unknown drug-induced anaphylaxis is a reason for exclusion; Antibiotic allergy, antipyretic allergy are NOT!)** |  |  |
| Have you had any acute illness in the last 4 weeks? |  |  |
| Did you have a fever in the last 2 weeks?  **(Note: Acute febrile illness is a reason for exclusion; PCR-confirmed infection within 3 months is a reason for exclusion)** |  |  |
| Do you suffer from an autoimmune disease that has its active phase at the moment? |  |  |
| In the last 3 months, have you received treatment that weakens your immune system, such as: cortisone, prednisone, other steroids, immunobiologicals or anti-tumour agents, or radiotherapy? |  |  |
| Have you ever had a seizure, nervous system problem, paralysis? |  |  |
| Do you suffer from hematopoietic disease or increased bleeding? |  |  |
| Have you been vaccinated in the last 2 weeks? |  |  |
| Do you currently have any symptoms? |  |  |
| Are you pregnant now? |  |  |
| Are you planning to become pregnant within 2 months? |  |  |
| Do you breastfeed? |  |  |

Date:……………………………

……………………………………… Signature