

Personal data of the person to be vaccinated

Surname*

First name*

Social insurance number (all 10 digits)*

Date of birth (DD.MM.YYYY)*

Gender:*

female

male

diverse

inter

open

no entry

Address (postcode, place, street, house number, block, door number)

Telephone number

Email address

Name of legal representative, if applicable

Please answer the following questions

Tick as applicable

1. Have you been diagnosed with **COVID-19 (confirmed by a PCR test)** during the past 6 to 8 months?

Yes

No

If yes, when?

2. During the last 7 days, have you been suffering, or are you still suffering, from any **acute disease**

Yes

No

or infection (e.g. fever, cough, common cold, sore throat, others)?

If yes, from what?

3. Have you ever had any **allergic shock involving a drop in blood pressure, pronounced respiratory distress or collapse?**

Yes

No

If yes, to what?

4. Are you currently undergoing any **allergen-specific immunotherapy / hyposensitisation therapy?**

Yes

No

When was the last time you received
any relevant medication?

When are you going to receive the next
medication?

5. Have you ever experienced any **complaints or adverse effects after being vaccinated** in the past

Yes

No

(except for minor local reactions such as redness, swelling, pain at the injection site or a touch of fever)?

If yes, after which vaccination and what kind
of reactions?

6. Are you regularly taking any **blood-thinning medication?**

Yes

No

If yes, which?

7. Are you suffering from any **serious or chronic diseases** (e.g. immunodeficiency, cancer, autoimmune disorder,

Yes

No

bleeding disorder, chronic inflammatory diseases)?

If yes, which?

8. Are you currently undergoing any **chemotherapy and/or radiotherapy** or are you taking any **immuno-**

Yes

No

suppressive drugs (e.g. cortisol)?

If yes, which?

9. Are you planning to undergo **surgery?**

Yes

No

If yes, when?

10. Have you been **vaccinated against any other disease within the past 4 weeks?**

Yes

No

If yes, which and when?

11. Are you **pregnant?**

Yes

No

If yes, how far along are you?

Informed consent

Following vaccination against COVID-19, reactions to the vaccine often occur which usually disappear on their own within a few days. Pain, reddening or swelling may very often occur at the vaccination site. Symptoms such as tiredness, headache, muscle or joint pain, swelling of the lymph nodes, nausea/vomiting, shivering or fever are also very often experienced. Very often means that more than 1 in 10 vaccinated persons are affected. Very rare blood clots, frequently in unusual places (such as the brain, the intestines, liver or spleen) have been observed after vaccination with Vaxzevria, simultaneously with a low blood platelet count and in some cases accompanied by bleeding. These have included some serious cases with blood clots in various or unusual places and excessive clotting or bleeding in the entire body. Most of these cases occurred within the first two weeks after vaccination and mostly affected women under the age of 60. Some of the cases had fatal outcomes. See a doctor immediately if you experience shortness of breath, chest pains, swelling in the legs or persistent abdominal pain after the vaccination. You should also contact a doctor immediately if you have severe or persistent headaches some days after the vaccination, if you experience blurred vision, or when bruises or punctiform round spots or patches appear around the vaccination site after a few days. For details, please refer to the enclosed leaflet. Upon request we can also provide a patient information leaflet on paper. Should you have any further questions, please get in touch with your doctor. Please scan this QR code for additional information about the Vaxzevria COVID-19 vaccine.



With my signature I confirm:

- that I have read and understood the leaflet regarding the vaccine described therein, or that I was otherwise provided with sufficient information about the same. I have been able to obtain information about potential adverse effects and possible arguments why I should not be vaccinated.
- that I am appropriately aware of the benefits and risks of the vaccination and accordingly do not require any further personal consultation,
- that I consent to being vaccinated free of charge, and
- that I am aware that my personal data are going to be processed in the vaccination register in accordance with the Gesundheitstelematikgesetz 2012 (see <https://www.elga.gv.at/datenschutzerklaerung>).



If you do NOT consent to being vaccinated or if you need to be provided with additional information by a doctor, please do NOT sign this informed consent.

For underage persons (children under the age of 14) or persons under disability, consent must be obtained from the legal representative (parents or legal guardians/authorised agents) of the person to be vaccinated. Adolescents must consent themselves, if they are capable of making decisions.

Date (DD.MM.YYYY) Signature of the person to be vaccinated or their legal representative

--	--

Important information: For your own safety, you should stay near the vaccinating physician for some 20 minutes, on the off chance of any reactions occurring (nausea, collapse, allergic reactions etc.).

Adverse reactions may be reported by vaccinated persons / their relatives; your attending physician and your pharmacist are even obliged to do so. If you suspect to experience any adverse reactions, please contact your doctor or pharmacist, report the same online at <https://www.basg.gv.at> or call 0800 555 621.



To be completed by the vaccination centre

Vaccination centre/organisation (contract partner number, if available)* Room for doctor's remarks

--	--

Agreed vaccine:* Vaccine dose:* 1st dose Left upper arm Prepared by third party
 AstraZeneca: Vaxzevria 2nd dose Right upper arm

Batch number (LOT or Ch.B)*

Date of vaccination (DD.MM.YYYY)*

--	--

Name of physician in charge*

Name of person administering the vaccine (if not the same)

--	--

Citizen
 not clearly identifiable

Signature of physician in charge

--