

Personal data of the person to be vaccinated – COVID-19 Vaccine Janssen

Version 3, as at: 10/06/2021

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 ever had any **SARS-CoV-2 infection** (confirmed by a PCR test), **COVID-19** (confirmed by a PCR test) or **antibodies against the coronavirus** (neutralisation test or correlate to neutralisation test **only**)?

Yes

No

If yes, when?

2. During the last 7 days, have you been suffering, or are you still suffering, from any **acute disease or infection** (e.g. fever, cough, common cold, sore throat, others)?

Yes

No

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. Have you already been **vaccinated against COVID-19**, have you been **vaccinated against any other disease within the past 4 weeks**, or are you currently undergoing any **allergen-specific immunotherapy/hyposensitization therapy**?

Yes

No

If yes, which and when?

5. Have you ever experienced any **complaints or adverse effects after being vaccinated** in the past (except for minor local reactions such as redness, swelling, pain at the injection site or a touch of fever)?

Yes

No

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

6. Are you **allergic to any medication** or to an **ingredient of the vaccine** (see information leaflet)?

Yes

No

If yes, to which?

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

Yes

No

If yes, which?

8. Are you suffering from any **severe or chronic diseases** (e.g. immunodeficiency, cancer, autoimmune disorder, bleeding disorder, chronic inflammatory diseases)?

Yes

No

If yes, which?

9. Are you currently undergoing any **chemotherapy** and/or **radiotherapy** or are you taking any **immunosuppressive drugs** (e.g. cortisol)?

Yes

No

If yes, when?

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

Yes

No

If yes, when?

11. Are you **pregnant**?

Yes

No

If yes, how far along are you?

Informed consent – COVID-19 Vaccine Janssen

Following vaccination against COVID-19, reactions to the vaccine often occur which usually disappear on their own within a few days. Pain may occur very often at the vaccination site; reddening or swelling may occur often. Moreover, severe fatigue, nausea, headache and muscle aches may occur very often; joint aches, cough, shivering and fever may occur often. Very often means that more than 1 in 10 vaccinated persons are affected; often means that up to 1 in 10 vaccinated persons is affected. Severe allergic reactions may occur. Strenuous physical activities should be avoided in case of exhaustion or fever. The combination of blot clots and a low level of platelets (cells involved in blood coagulation) in the blood was observed very rarely after administration of the COVID-19 Vaccine Janssen. This includes severe cases of blood clotting, among others in unusual places (e.g. brain, liver, colon, spleen), in some cases combined with bleedings. These cases occurred within the first three weeks after vaccination, mostly in women below the age of 60. One fatal outcome was reported. Seek urgent medical attention if you experience any of the following symptoms within the first three weeks after your vaccination:

- Severe or persistent headaches, blurred vision, mood changes or seizures;
- Shortness of breath, chest pain, swollen legs, leg pain or persistent stomach ache;
- Unusual bruising on your skin or round pinpoint spots beyond the vaccination site.

For details, please refer to the information leaflet provided electronically. You may also request a hard copy of the information leaflet. Should you have any further questions, please get in touch with your doctor. In order to access the information leaflet of the COVID-19 Vaccine Janssen, please scan the QR code (<https://www.basg.gv.at/konsumentinnen/wissenswertes-ueber-arzneimittel/covid-19-impfstoffe>).



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, legal guardians or authorised agents) of the person to be vaccinated. Adolescents (mature underage persons who have completed the age of 14) 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

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

If you suspect to experience any adverse reactions, please contact your doctor or pharmacist. They are obliged to report any suspected adverse reactions. However, you or members of your family may report adverse reactions as well. More information is available online at www.basg.gv.at/pharmakovigilanz/meldung-von-nebenwirkungen; you can also call 0800 555 621.



Please note: Leave this section blank – To be completed by the vaccination centre only

Vaccination centre/organisation (contract partner number, if available)*

Room for doctor's remarks

Left upper arm

Right upper arm

Prepared by third party

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 as physician in charge)

Citizen
not clearly identifiable

Signature of physician in charge