Federal Ministry
Republic of Austria
Social Affairs, Health, Care and Consumer Protection

Information and documentation form / COVID-19 vaccination

Please complete the mandatory fields for the vaccination register (marked with "*") under all circumstances.

Informative, non-authoritative translation! Don't fill in!

Personal data of the person to be vaccinated – COVID-19 mRNA vaccines

Version 7, 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 **immuno-suppressive 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?

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The German text is authoritative; no liability shall be assumed for potential translation errors or for the relevance of the present translation in the event of a future revision of the German-language original.

Version 7, as at: 10/06/2021

Informed consent – COVID-19 mRNA vaccines

Following vaccination against COVID-19, reactions to COVID-19 mRNA vaccines often occur which usually go away on their own within a few days. Pain or swelling may occur very often at the injection site; reddening, rashes or urticaria may occur often. Moreover, (extreme) tiredness, headache, muscle and joint aches, joint stiffness, swelling in the armpits, nausea, vomiting, diarrhoea, shivering and fever may occur very often; rashes 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. 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 approved COVID-19 vaccines, 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**

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 cal 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

Agreed vaccine:*

- ◯ BioNTech/Pfizer: Comirnaty
- ◯ Moderna: COVID-19 Vaccine Moderna
- ◯ Other:

Vaccine dose:*

- ◯ First dose
- ◯ Second dose

☐ Prepared by third party

- ◯ Left upper arm
- ◯ 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 as physician in charge)

☐ Citizen not clearly identifiable

Signature of physician in charge