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| Name:       | Civic reg. no.:       |
| Telephone number:       |
| Employer:       |
| **Before your vaccination, please answer the following questions:** |
| 1. Do you have a fever or an acute infection now? | YES [ ]  | NO [ ]  |
| 2. Have you ever had any problems with vaccinations? | YES [ ]  | NO [ ]  |
| 3. Do you have allergies that have ever given you severe reactions for which you have needed  hospital care? | YES [ ]  | NO [ ]  |
| 4. Are you allergic to eggs? | YES [ ]  | NO [ ]  |
| 5. Do you have any diseases?If YES, which one(s)?       | YES [ ]  | NO [ ]  |
| 6. Do you take any medications?If YES, which one(s)?       | YES [ ]  | NO [ ]  |
| 7. Are you pregnant? | YES [ ]  | NO [ ]  |
| 8. Have you recently had any other vaccinations (within the past month)? | YES [ ]  | NO [ ]  |
| 9. Do you have any bloodborne diseases (Hepatitis B, Hepatitis C, or HIV)? | YES [ ]  | NO [ ]  |
| Date:       | Signature employee: |
| Date of vaccination:       | Vaccinator:       |
| Vaccine:       | Prescriber:       |
| Dose:       | Route of administration:  | IM right arm [ ]  | IM left arm [ ]  |
| Batch-/Lot number:       | Other localisation, if applicable:       |
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