

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

Version 8, as at: 04/08/2021

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? If yes, to what?

Yes

No

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? If yes, which and when?

Yes

No

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, 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, which?

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 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. Myocarditis and pericarditis were reported very rarely. 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 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

Agreed vaccine:*

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

Vaccine dose:*

- 1st dose
 2nd 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