Annex IV

*Name and registration code of the vaccination institution*

**Form for assessing a person's health status prior to vaccination against Covid-19**

**PERSONAL SECTION (ages 12+)**

|  |  |  |
| --- | --- | --- |
|   | **Date**  |   |

Person's name, surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal number

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   |   |   |   |   |   |   | –  |   |   |   |   |   |   |

Please answer the following questions about your health status (*circle the appropriate one*):

|  |  |  |
| --- | --- | --- |
| Are you known to be allergic to any of the substances in the vaccine (polyethylene glycol (PEG) or other substances, containing pegylated molecules)?  | Yes  | No  |
| Have you had an anaphylactic reaction (a severe allergic reaction) after receiving any vaccine or injectable medicine?  | Yes  | No  |
| Do you currently experience any symptoms of an acute infection, do you have a high temperature or other malaise?  | Yes  | No  |
| Are you currently taking any immunosuppressive drugs, glucocorticosteroids, biologic drugs, beta blockers?  | Yes  | No  |
| Are you pregnant (for females)?  | Yes  | No  |
| Have you received any vaccine in the last 14 days?  | Yes  | No  |
| Have you been diagnosed with a Covid-19 infection with a positive SARS-CoV-2 PCR test?  | Yes  | No  |
| Have you already received any Covid-19 vaccine?  | Yes  | No  |
| Do you use oral contraceptives (for females)?  | Yes  | No  |
| Do you smoke?  | Yes  | No  |
| Have you had any serious, prolonged (45<min) surgery in the last three months?  | Yes  | No  |
| Have you had long-term limited mobility during the last month, such as sitting for 14 hours or sleeping for more than 12 hours (bed rest after surgery, fractures)?  | Yes  | No  |
| Have you had a leg fracture, hip or knee replacement in the last three months?  | Yes  | No  |
| In the last three months, have you been hospitalized for myocardial infarction, heart failure or arrhythmia?  | Yes  | No  |
| Have you had a blood clot?  | Yes  | No  |
| Are you currently receiving chemotherapy for a tumor?  | Yes  | No  |
| Have you had a history of immune thrombocytopenia (bleeding due to low platelet counts or bruising or superficial bleeding in the skin and you are under a haematologist’s care)?  | Yes  | No  |
| Have you been diagnosed with capillary leak syndrome (leakage of fluid from small blood vessels)?  | Yes  | No  |

**Regarding the epidemiological risks of receiving a booster dose**

|  |  |  |
| --- | --- | --- |
| Do you have long-term contact with other people outside the household, in physical contact or for a long-term closer than two meters, indoors (e.g. in a classroom, meeting room, hospital waiting room, office) or on regular public transport commute for more than 15 minutes?  | Yes  | No  |
| Do you have an increased risk of becoming infected through direct contact with people whose health status is unknown?  | Yes  | No  |
| Do you have a chronic illness (arterial hypertension, bronchial asthma, diabetes, etc.)?  | Yes  | No  |

The person certifies that he/she has provided true information and that the medical practitioner has provided information about the vaccination.

Legal representative of the person, if the questionnaire is not filled in by the person

Name, Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the person to be vaccinated (or legal representative)

|  |  |  |
| --- | --- | --- |
|   | Name, surname  |    |

**Form for assessing the health status of a child aged 5 to 11 years before vaccination with Covid-19**

**PERSONAL SECTION**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Child's name, surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Child’s personal number

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Legal representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions about your child’s health status (*circle the appropriate one*):

|  |  |  |
| --- | --- | --- |
| Is the child known to be allergic to any of the substances in the vaccine (polyethylene glycol (PEG) or other substances, containing pegylated molecules)? | **Yes** | **No** |
| Has the child had an anaphylactic reaction (a severe allergic reaction) after receiving any vaccine or injectable medicine?   | Yes    | No    |
| Is the child currently experiencing any symptoms of an acute infection, does he/she have a high temperature or other malaise?   | Yes    | No    |
| Is the child currently taking immunosuppressive drugs, glucocorticosteroids, biologic drugs or beta-blockers?    | Yes    | No    |
| Has the child been diagnosed with a Covid-19 infection with a positive SARS-CoV-2 PCR test)?  | Yes    | No  |
| Has the child already received any Covid-19 vaccine? | Yes   | No  |

 The legal representative certifies that the information provided is true and the medical practitioner has provided information about the vaccination, incl. about the possible adverse reactions and how to deal with them.

Signature of the legal representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_