Consent form for vaccination against:

☐ cholera	☐ hepatitis B	☐ pneumococci
☐ diphtheria	☐ Japanese encephalitis	☐ rabies
☐ TBE (tick-borne encephalitis)	☐ whooping cough (pertussis)	☐ typhoid
☐ yellow fever	☐ poliomyelitis (polio)	☐ chickenpox (varicella)
☐ flu (influenza)	☐ measles, mumps, rubella	☐ tetanus
☐ hepatitis A	☐ meningococci	

surname, first name: _____

date of birth: _____

We kindly ask you to provide the following information on your health status, so that the doctor can decide if you can be vaccinated effectively and risk-free today:

signs of acute illness (e.g. feverish infection):
☐ no ☐ yes, the following: _____

serious chronic illness (including epilepsy):
☐ no ☐ yes, the following: _____

administration of medication or treatment within the last three months which may affect the immune system, such as cortisone, gamma globulin, immunosuppressives:
☐ no ☐ yes, the following: _____

are you taking any anticoagulants (e.g. Warfarin, Marcumar, Falithrom, heparin):
☐ no ☐ yes, the following: _____

do you have any allergies, (e.g. egg white, antibiotics, other):
☐ no ☐ yes, the following: _____

previous vaccination complications (e.g. allergic reaction, high fever):
☐ no ☐ yes, the following: _____

other vaccinations in the past 4 weeks:
☐ no ☐ yes, the following: _____

are you pregnant?
☐ no ☐ yes

All recommended vaccinations are normally well-tolerated and provide a high level of efficacy. For legal reasons it is our duty to explain to you all side-effects that may possibly occur. Each vaccination can cause local reactions such as pain, redness, and hardening on the site of injection. The vaccination you require has been marked on this consent form. Please carefully read the information in the attached vaccination leaflet before getting vaccinated.

I hereby confirm that I have read and understood the information given. I have had the opportunity to ask questions and agree to being vaccinated.
I would like a copy of this form □ yes □ no

city, date: _____ **signature:** _____

Optional information:
Date of vaccination _____ Batch sticker
Place of vaccination – upper arm: left □ right □ sc □ i.m. □

Stamp/signature doctor_____

delegated to assistant:

_____
surname, first name