SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA

ICARE

CONSENT FORM
UPDATED ON 25/03/2021

First name and surname:	
Date of birth:	Place of birth:
Address:	Telephone:
National Health Card (if available) Tax Code	

I have read, in a language known to me, and have fully understood the Information Leaflet issued by the Italian Medicines Agency (AIFA) for the vaccine: " .... "

I have informed the doctor about any current and/or past illnesses and ongoing treatment. I was given the chance to ask questions about the vaccine and my state of health, and received comprehensive answers that I understood. I was properly informed in words that were clear to me. I understand the benefits and risks of the vaccination, the methods and alternatives, and the consequences of refusing or refraining from completing the vaccination with the second dose, if applicable.

I am aware that if any side effects occur, it is my responsibility to inform my doctor immediately and follow their instructions.

I agree to stay in the waiting room for at least **15 minutes** after administration of the vaccine to ensure that no immediate adverse reactions occur.

I AGREE TO AND AUTHORISE the administration of the vaccine	**I DO NOT AGREE TO** the administration of the vaccine ....
Date and place:	**Date and place:**
Signature of the person receiving the vaccine or their legal representative	**Signature** of the person refusing the vaccine their legal representative ....

Information to relatives of persons unable to give consent (Ref. Italian Law 29 January 2021, no.6)

☐ The patient is unable to provide informed consent. In order to protect the patient's health, and in view of the recommendation for vaccination, the decision to proceed with the COVID-19 vaccination is shared with the family member. *cf. COVID19 vaccination recommendation form shared with relatives*

Date and place:............................ **Relative's signature**:...

Vaccination team members

1. First name surname and role	**2. First name surname and role**
I confirm that the vaccine recipient has given their consent to the vaccination, after receiving adequate information **Signature:**	I confirm that the vaccine recipient has given their consent to the vaccination, after receiving adequate information **Signature:**

The presence of a second health care professional is useful but not essential in the case of home vaccination or in a critical logistical and organisational context

Vaccination administration details

	Site of injection		Batch no.	Expiry	Where administered	Date and time	Immuniser signature
First dose	Right arm	Left arm					
Second dose	Right arm	Left arm					

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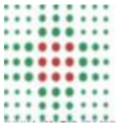

SARS-CoV-2/COVID-19 VACCINATION PRE-VACCINE TRIAGE

To be completed by the vaccine recipient and reviewed with the vaccination health care professionals

First name and surname: ……………………………………………………………………… **Date and place of birth:** …………….. ……………………………………………			**Telephone:** ………………………………..
MEDICAL HISTORY	***YES***	***NO***	***Don't know***
Are you feeling unwell today?			
Do you have a high temperature?			
Are you allergic to latex, any foodstuffs, medicines or any of the vaccine ingredients? If yes, please specify:………………………………………………			
Have you ever had a serious reaction after receiving a vaccine?			
Do you suffer from heart or lung disease, asthma, kidney disease, diabetes, anaemia or other blood disorders?			
Are you immunosuppressed? *(e.g. cancer, leukaemia, lymphoma, HIV/AIDS, transplant)*			
In the last 3 months, have you taken any medicine that affects your immune system *(e.g. cortisone, prednisone or other steroids)* or anti-cancer drugs, or have you undergone radiation treatment?			
Over the last year, have you received a blood transfusion or blood products, or have you been given immunoglobulins (gamma) or antiviral drugs?			
Have you had any seizures or any problems with your brain or nervous system?			
Have you received any vaccinations in the last 4 weeks? If yes, which?			
Are you taking any anticoagulant medication?			
Specify below the medicines, as well as any natural supplements, vitamins, minerals or alternative medicines you are taking: ……..			
FOR WOMEN ONLY:	***YES***	***NO***	***Don't know***
Are you pregnant or are you considering getting pregnant in the month following the first or second dose?			
Are you breast-feeding?			
COVID-RELATED MEDICAL HISTORY	***YES***	***NO***	***Don't know***
In the last month, **have** you been in contact with a person infected with Sars-CoV2 or suffering from COVID-19?			
Have you had any of the following symptoms:			
- Cough/cold/high temperature/breathlessness or flu-like symptoms?			
- Sore throat/loss of sense of smell or taste?			
- Abdominal pain/diarrhoea?			
- Abnormal bruising or bleeding/reddening of the eyes?			
Have you travelled abroad in the last month?			
COVID-19 TESTS			
☐ No recent COVID-19 test ☐ Negative COVID-19 test (Date:............................) ☐ Positive COVID-19 test (Date: ....) ☐ Waiting for COVID-19 test (Date:............................)			
Report any other conditions or useful information about your health: ………			

Date and place		**Signature** of the vaccine recipient or their legal representative	