

## Declaration of consent for vaccination with

### Celvapan®

The **vaccine** is an inactivated whole virion vaccine that contains an antigen of a pandemic strain A/California/07/2009 (H1N1)\* and is Vero cell derived.

	If vaccinating an adult	If vaccinating a child
Have you/your child ever experienced complaints or adverse effects following a vaccine?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
Do you/your child presently have a fever or have you/your child experienced a fever within the past 2 weeks? Are you/your child presently suffering from a cough, runny nose, saw throat? Do you/your child have any other form of infection at present?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
Do you/your child suffer from any allergies? If yes, which one(s)?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
Do you/your child suffer from hereditary or acquired immune deficiency? Do you/your child take medication to assist the immune system, e.g. cortisone? Are you/your child presently undergoing chemotherapy or radiotherapy?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
Do you/your child suffer from a severe or chronic illness and/or are you receiving treatment for this now or have you done so in the past?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
Do you/your child take blood thinning medication? If yes, which?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
Do you/your child suffer from a chronic inflammatory disease of the brain or spinal cord? Have you/your child ever had an epileptic fit?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
Are you pregnant?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>

**In the interest of your personal safety, please remain in close proximity to the physician for 20 minutes after the vaccination in case of any adverse reactions (nausea, collapse, allergic reaction).**

**Note:**

The inoculation against the new strain of influenza does not provide protection against “seasonal influenza” which is triggered by other strains of the influenza virus.

*Continued overleaf*

**I hereby confirm that I have carefully read and am fully aware of the contents of this information sheet. I have been informed here of the potential adverse effects of the vaccination and have understood this information. I have been given the opportunity to discuss any open questions with the physician and have no further questions in this regard.**

**I hereby consent to receiving the vaccination.**

yes  no

**I hereby consent to my child receiving the vaccination.**

yes  no

*To be completed by the vaccine recipient*

Surname:

Forename:

Date of birth:

Social security number:

Social security provider:

\_\_\_\_\_  
Date and signature of the vaccine recipient or legal guardian:

\_\_\_\_\_  
Name of the vaccine centre

This questionnaire serves to support discussion with the physician although it cannot replace this. I have provided the vaccine recipient with the opportunity for personal discussion.

Physician's signature and stamp

Batch label

Date \_\_\_\_\_

***TO BE COMPLETED BY THE PHYSICIAN***