Federal Ministry
Republic of Austria
Social Affairs, Health, Care
and Consumer Protection

Information and documentation form / COVID-19 vaccination

Please complete the mandatory fields for the vaccination register (marked with "*") under all circumstances.

Informative, non-authoritative translation! Don't fill in!

Standard Version 5 as at 9 April 2021

Personal data of the person to be vaccinated

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 been diagnosed with **COVID-19 (confirmed by a PCR test)** during the past 6 to 8 months? ◯ 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**? ◯ Yes ◯ No
   If yes, to what?

4. Are you currently undergoing any **allergen-specific immunotherapy / hyposensitisation therapy**? ◯ Yes ◯ No
   When was the last time you received any relevant medication?
   When are you going to receive the next medication?

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 regularly taking any **blood-thinning medication**? ◯ Yes ◯ No
   If yes, which?

7. Are you suffering from any **serious** or **chronic diseases** (e.g. immunodeficiency, cancer, autoimmune disorder, bleeding disorder, chronic inflammatory diseases)? ◯ Yes ◯ No
   If yes, which?

8. Are you currently undergoing any **chemotherapy** and/or **radiotherapy** or are you taking any **immuno-suppressive drugs** (e.g. cortisol)? ◯ Yes ◯ No
   If yes, which?

9. Are you planning to undergo **surgery**? ◯ Yes ◯ No
   If yes, when?

10. Have you been **vaccinated against any other disease within the past 4 weeks**? ◯ Yes ◯ No
    If yes, which and when?

11. Are you **pregnant**? ◯ Yes ◯ No
    If yes, how far along are you?

Standard Version 5 as at 9 April 2021

Informed consent

Following vaccination against COVID-19, reactions to the vaccine often occur which usually disappear on their own within a few days. Pain, reddening or swelling may very often occur at the vaccination site. Symptoms such as tiredness, headache, muscle or joint pain, swelling of the lymph nodes, nausea/vomiting, shivering or fever are also very often experienced. Very often means that more than 1 in 10 vaccinated persons are affected. For details, please refer to the enclosed leaflet. Upon request we can also provide a patient information leaflet on paper. Should you have any further questions, please get in touch with your doctor.
Please scan this QR code for more information about COVID-19 vaccines.

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 consulation,
- 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 or legal guardians/authorised agents) of the person to be vaccinated. Adolescents 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 physician for some 20 minutes, on the off chance of any reactions occurring (nausea, collapse, allergic reactions etc.).
Adverse reactions may be reported by vaccinated persons / their relatives; your attending physician and your pharmacist are even obliged to do so. If you suspect to experience any adverse reactions, please contact your doctor or pharmacist, report the same online at https://www.basg.gv.at or call 0800 555 621.

To be completed by the vaccination centre

Vaccination centre/organisation (contract partner number, if available)* | Room for doctor's remarks

Agreed vaccine:*

- ◯ BioNTech/Pfizer: Comirnaty
- ◯ Moderna: COVID-19 Vaccine Moderna
- ◯ Janssen: COVID-19 Vaccine Janssen
- ◯ 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)

☐ Citizen not clearly identifiable

Signature of physician in charge