COVID-19 VACCINATION CONSENT FORM FOR CHILDREN

Name and Surname of the vaccinee:	
Date of birth:	Place of birth:
Permanent address:	Phone:
Health insurance card no. (if available)	

Name and Surname of parent/guardian/other person with parental responsibility:

Born in (place)_____On (date)_____

Permanent address _____

Name and Surname of parent/guardian/other person with parental responsibility:

Born in (place)_____On (date)_____

Permanent address _____

I reported to the Doctor current and/or previous diseases and therapies in progress.

I had the opportunity to ask questions about the vaccine and the state of health of the child, I obtained comprehensive answers and I understood them.

I was clearly informed. I understood the benefits and risks of vaccination, modalities and therapeutic alternatives, as well as consequences of a possible refusal or renunciation of completing the vaccination with the second dose, if necessary.

I am aware that if any side effect occurs, I am responsible for immediately informing my family doctor and for carrying out the instructions.

I agree to remain in the waiting room with the child for at least 15 minutes after the vaccination in order to ensure that no immediate adverse reactions occur.

I consent and authorize the inoculation of the vaccine _____:

Date and place _____

Signature of parent/guardian/other person with parental responsibility

_____

I refuse the inoculation of the vaccine _____:

Date and place _____

Signature of parent/guardian/other person with parental responsibility

_____

Health professionals of the vaccination team

1. Name and Surname (Doctor) .....

I confirm that the parent/guardian/other person with parental responsibility was adequately informed and has given his/her consent to the vaccination.

Signature ....

2. Name and Surname (Doctor or other Healthcare Professional)

.....

Position.....

I confirm that the parent/guardian/other person with parental responsibility was adequately informed and has given his/her consent to the vaccination.

Signature ....

The presence of the second Health Professional is not essential in the case of Vaccination at home or in a difficult logistical-organizational situation.

Vaccination details

	Injection site		Lot no.	Expiration date	Place of vaccination	Date and time of vaccination	Signature of the Professional
1st dose	Right arm	Left arm					
2nd dose	Right arm	Left arm					

COVID-19 VACCINATION - ANAMNESTIC SHEET FOR CHILDREN

The parent/guardian/other person with parental responsibility will fill in this form and review its content with the Health Professionals of the vaccination team.

Name and Surname:	Phone:		
Anamnesis of the vaccinee	**YES**	**NO**	**I don't know**
Are you currently sick?			
Do you have a fever?			
Do you suffer from allergies to latex, food, drug or vaccine components? If yes, please specify:……			
Have you ever had a severe reaction after receiving a vaccine?			
Do you suffer from heart or lung disease, asthma, kidney disease, diabetes, anaemia or other blood disorders?			
Are you in a condition of compromised immune system? (for example: cancer, leukaemia, lymphoma, HIV/AIDS, transplant)?			
In the past 3 months, have you taken any medications that weaken the immune system (for example: cortisone, prednisone or other steroids) or anticancer drugs, or have you undergone radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, or have you been given immunoglobulins (gamma) or antiviral drugs?			
Have you had convulsion attack or any problems with your brain or nervous system?			
Have you received any vaccinations in the past 4 weeks? If yes, please specify:.....			
For women: - are you pregnant or are you planning to become pregnant in the month following the first or second dose of vaccine?			
- are you breastfeeding?			
Are you taking anticoagulant medications?			

Specify below the drugs, and in particular those anticoagulants, as well as natural supplements, vitamins, minerals or any alternative medicines you are taking:

COVID-related anamnesis	**YES**	**NO**	**I don't know**
Have you been in contact with a person infected with Sars-CoV2 or affected by COVID-19 in the last month?			
You have any of the following symptoms:			
Cough/cold/fever/dyspnoea or flu-like symptoms?			
Sore throat/loss of smell or taste?			
Abdominal pain/diarrhoea?			
Abnormal bruising or bleeding/redness of the eyes?			
Have you made any international trip in the last month?			
COVID-19 testing: No recent COVID-19 testing COVID-19 testing negative (Date: _____) COVID-19 testing positive (Date: _____) Waiting for COVID-19 testing (Date: _____)			

Report any other disease or useful information about your state of health

Place and date _____

Signature of the Healthcare professional _____