

PERSONAL MEDICAL SHEET

You must read the Vaccination Patient's Charter and the information statement before completing this questionnaire

ADULT

Pre-A(H1N1) 2009 vaccination questionnaire			
Surname:	First name:	Date of birth:	
Address:			
Answer all questions by ticking the corresponding boxes on this form.		Answer	
		YES	NO
1	Have you been vaccinated against seasonal influenza in the past 3 weeks?		
2	Have you had any serious reaction when vaccinated or a contra-indication for a vaccination?		
3	Do you have an allergy to egg or chicken proteins, to ovalbumin or to certain drugs? (<i>Do not mention digestive intolerance to eating eggs or chicken meat.</i>)		
4	Do you currently have a temperature?		
5	Are you currently ill or have you recently been ill? (<i>Do not mention common diseases like colds, eczema, etc., but be sure to mention confirmed influenza or suspected influenza.</i>)		
6	Are you or have you been under special medical supervision?		
7	Are you suffering from coagulation problems or taking an anticoagulant?		
8	Have you been on a medical treatment for more than 30 days in the past 6 months (<i>aside from contraception</i>)?		
9	For women: are you pregnant or do you think you may be pregnant?		

To be completed by the medical officer:

Name of medical officer	Signature of medical officer	Date
Observations:		
Medical prescription (name of vaccine and dose):		

To be completed by the patient:

- I have read the Vaccination Patient's Charter and the Vaccine Information Statement (*tick the box if your answer is yes*)
- I have been given information on the vaccine and on vaccination risks (*tick the box if your answer is yes*)
- I want to be vaccinated (*tick the box if your answer is yes*)
- I do not want to be vaccinated (*tick the box if your answer is yes*)

Date and patient's signature (required):

Vaccination centre	Name of vaccine	Batch number