Stadt Wien | Gesundheitsdienst

VIENNA CITY ADMINISTRATION

Municipal Department 15 – Public Health Services

CONSENT FORM for VACCINATION AGAINST the SARSCoV2 VIRUS Comirnaty® mRNA Vaccine

PLEASE ANSWER THE FOLLOWING QUESTIONS:

(☒ Mark as applicable)

Question	yes	no
Has your child ever experienced **serious problems** or **side effects** after being vaccinated in the past, except for minor local reactions, such as redness, swelling, pain at the injection site or a slight temperature? If yes, which ones?……………………………………………………………………………	yes ☐	no ☐
Has your child been ill with a **fever** in the last 2 weeks? Is your child currently ill with a fever, cough, cold, sore throat? Does your child currently have any other infection?	yes ☐	no ☐
Does your child suffer from an **allergy** (e.g. chicken egg white, medicines)? If yes, from which one? ……………………………………………………………………………………………… If your child is currently undergoing an allergy injection therapy: When was the last injection?…………………………………………… When is the next injection scheduled for?………………………………	yes ☐	no ☐
Does your child suffer from any primary or secondary **immune deficiency/ immune disease**? If yes, which one? ………………………………………………………………………	yes ☐	no ☐
Does your child take any regular **medications** (e.g. cortisone, cytostatics, blood-thinning medications)? If yes, which ones? …………………………………………………………………………………………………… ……………………………………………………………………………………………………	yes ☐	no ☐
Is your child currently undergoing **chemotherapy** and/or **radiotherapy**?	yes ☐	no ☐
Does your child suffer from **severe** or **chronic diseases** (e.g. cancer, autoimmune diseases, coagulation disorders)? If yes, from which ones? …………………………………………………………………………………	yes ☐	no ☐
Has your child recently undergone any **invasive procedure** (e.g. **surgery**)?	yes ☐	no ☐
Is your child suffering from any **chronic inflammatory disease of the brain or spinal cord**?	yes ☐	no ☐
Has your child ever had **epileptic seizures**?	yes ☐	no ☐
Has your child received **blood**, **blood products** or **immunoglobulins** in the **last 3 months**?	yes ☐	no ☐
If applicable, is your adolescent daughter **pregnant**?	yes ☐	no ☐
Has your child received any **other vaccination** in the **last 4 weeks**? If yes, which one and when?……………………………………………………………………………… …………………………………………………………………………………………………	yes ☐	no ☐

Please turn over – thank you!

Please fill in in capitals – thank you

-- --
Child's last name Child's first name

Address

-- --
Child's date of birth: day/month/year

Parent's/guardian's name

By signing, I confirm that I have carefully read and understood the information sheet and the instructions for the above-mentioned vaccine (Comirnaty®). Therein, I was informed about the composition of the vaccine, contraindications to and possible side effects of the vaccination, and I have understood this information.
I was offered the opportunity to discuss any open questions with the school's doctor during their office hours, but I am sufficiently informed about the benefits and risks of vaccination and therefore do not need a personal consultation.
I agree to the transfer of my data to the Public Health Service for the purpose of preparing anonymised statistics for the Federal Ministry of Social Affairs, Health, Care and Consumer Protection.

I consent to the administration of the vaccine.

....
Date Parent's/guardian's signature

PLEASE NOTE:
If you would like to make use of the opportunity to consult with the school's doctor in person during their office hours, we kindly ask you to sign this consent form only after the consultation and hand it over to the school's doctor at the end of your appointment.

Doctor's remarks:

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Date Doctor's stamp and signature