Declaration of consent for vaccination against influenza (flu):

☐ Influenza – with standard influenza vaccine (Flucelvax® - cell-based)

☐ Influenza – with MF-59 adjuvanted influenza vaccine (Fluad®)

Surname, first name: _____

born on: _____

So that the doctor can decide whether you can be vaccinated effectively and without particular risk today, we ask you to provide the following information about your state of health:
Signs of acute illness/s (e.g. infection with fever):
□ no □ yes, the following: _____

Severe chronic illness/s (also e.g. seizure disorders/epilepsy):
□ no □ yes, the following: _____

Have you taken medication or treatments that have a strong effect on the immune system within the last three months, e.g. cortisone, gamma globulins, immunosuppressants?
□ no □ yes, the following: _____

Are you taking blood-thinning medication, e.g. Marcumar, Falithrom, Heparin?
□ no □ yes, the following: _____

Are there any allergies, e.g. to chicken protein, antibiotics, etc.?
□ no □ yes, the following: _____

Previous vaccination complication(s) (e.g. allergic reactions, high fever)
□ no □ yes, the following: _____

Other vaccination/s in the past 4 weeks:
□ no □ yes, the following: _____

Are you pregnant?
□ no □ yes

All the vaccinations we recommend are very well tolerated and highly effective. For legal reasons, we must nevertheless inform you of all side effects that have ever occurred.
Each vaccination can cause local reactions such as pain, redness, swelling and hardening at the injection site. The vaccination intended for you has been marked on this declaration of consent. Please read the information in the enclosed vaccination information leaflet carefully before vaccination.
I hereby declare that I have read and understood the information. I was informed that the STIKO recommends an inactivated high-dose or MF-59 adjuvanted influenza vaccine for patients aged 60 and over, but that I can also be vaccinated with a standard influenza vaccine. I have read the information sheet thoroughly and had the opportunity to obtain further information during the consultation.
I had enough opportunity to ask questions. I agree to be vaccinated with the above vaccine.

I would like a copy of this form **□ yes** **□ no**

Place, date: _____ **Signature: _____**

Optional specification:

Date of vaccination _____ Batch sticker

Vaccination site – upper arm: left □ right □ sc □ i.m. □

Stamp/signature of doctor _____

delegated to assistant: Last name, first name _____