

Patient's full name: .....

PESEL or passport series and number: .....

Contact details (telephone number): .....

**COVID-19 pre-vaccination screening form for adults**  
**To be completed before visiting the vaccination site.**

The following questions will help the screening staff to determine whether you are eligible to be vaccinated against COVID-19 today. The answers will be used in making the decision whether you are eligible for vaccination. The screening staff may ask additional questions. If you have any doubts, please ask the screening staff or vaccinator for clarification.

No.	Pre-screening questions concerning exposure to COVID-19	Yes	No
1.	Have you had close contact or been living with someone who took a genetic or antigen test for SARS-CoV-2 and tested positive in the last seven days, or have you been living with a person experiencing COVID-19 symptoms (listed under Questions 2-4) within that period?		
2.	Have you experienced higher body temperature or a fever in the last seven days?		
3.	Have you been experiencing a sore throat, a new, continuous cough or a worsening chronic cough due to a diagnosed chronic condition in the last seven days?		
4.	Have you lost your sense of smell or taste in the last seven days?		
5.	Are you experiencing a cold, diarrhoea or vomiting?		

If you answered YES (affirmative) to any of these questions, your COVID-19 vaccination should be delayed. Please come back for your vaccination appointment only when you can answer NO (negative) to all questions. If you have any doubts, please contact the vaccination site.

**COVID-19 pre-vaccination medical history form for adults**

No.	Health questions	Yes <sup>a</sup>	No	Don't know <sup>a</sup>
	Are you feeling unwell today? (body temperature at vaccination site: .....°C)			
	Have you ever experienced any serious adverse reaction following vaccination (including following the first dose of a COVID-19 vaccine)? If so, what was the reaction? .....			
	Have you been diagnosed as allergic to polyethylene glycol (PEG), polysorbate, or other vaccine components <sup>1</sup> ?			
	Have you been diagnosed with a severe generalised allergic reaction (anaphylactic shock) after drug intake, food consumption, or insect bite?			
	Are you experiencing an exacerbated chronic condition?			

<sup>1</sup>For more information on COVID-19 vaccine components, please consult the patient leaflet available at the "Szczepimy się" website, <https://www.gov.pl/web/szczepimysie/materialy-informacyjne-dla-szpitali-i-pacjentow-dotyczace-szczepien-przeciw-covid-19>. You can also get the leaflet from your vaccinator.

No.	Health questions	Yes <sup>a</sup>	No	Don't know <sup>a</sup>
	Are you taking medication that weakens your immune system (immunosuppressants, oral corticosteroids, e.g. prednisone or dexamethasone), (cytostatic) drugs for malignant tumours or post-transplant medication, or are you undergoing radiation therapy or biological therapy for arthritis, inflammatory bowel disease (such as Crohn's disease) or psoriasis?			
	Do you suffer from haemophilia or other serious blood clotting disorders?			
	Have you been diagnosed with heparin-induced thrombocytopenia (HIT) or cerebral venous sinus thrombosis?			
	<i>(For women only)</i> Are you pregnant?			
	<i>(For women only)</i> Are you breastfeeding?			

<sup>a</sup> If you answered YES or DON'T KNOW to any of the questions, screening staff will have to ask you for additional clarification. If you answered YES to any of the health questions 2-8, this indicates that you should be screened by a medical practitioner.

Questions at the vaccination site		Yes	No
1.	Do you have any doubts concerning the questions asked?		
2.	Have you received answers to your questions?		

Legible signature of the patient: ..... Date: ..... / Time: .....

Form completed at vaccination site: .....

Deemed eligible for vaccination / not eligible for vaccination (underline as appropriate) by:

..... Date: ..... / Time: .....  
(legible signature of screening staff)

### Consent

I voluntarily give my consent to be vaccinated against COVID-19. I confirm that I have received and understood information about this vaccination. I have also received and understood answers to all questions I asked.

.....  
Date and legible signature