CENTRE DE VACCINATION DU BEAUVAISIS COVID-19

2nd injection

PFIZER

[2]

COVID-19 VACCINATION FILE

NAME :

SURNAME :

BIRTH DATE : / /

DATE OF FIRST INJECTION / /

We thank you :

- Bring the prescription of your current medical prescriptions
- Show up at the time of your appointment, not in advance
- Respect physical distancing and barrier gestures

Did you experience any side effects from the first injection ? Yes ❑ No ❑
If yes which ones ?.....

Have you received another vaccination in the past 2 weeks? Yes ❑ No ❑

Have you had any signs of COVID-19 infection since the first injection? (fever, dry cough, loss of smell or taste...) Yes ❑ No ❑
If YES, did you take a PCR or antigenic test ? Yes ❑ No ❑
Is it a positive ? Yes ❑ No ❑

Have you been in contact with a COVID-19 person ? Yes ❑ No ❑

Do you have a fever right now ? Yes ❑ No ❑

Have you had anticoagulant or fluidifying treatment prescribed since the first injection ? Yes ❑ No ❑

Are you less than 3 months pregnant or do you think you are ? Yes ❑ No ❑

Do you have treatment for hemostasis disorder or immunosuppressant ? Yes ❑ No ❑

Supplementary comment

REQUEST FOR INFORMED CONSENT

❑ I acknowledge that I have received the information, including the terms of this questionnaire, that I have answered it in all sincerity and I wish to be vaccinated.

Patient Date and Signature :

The / /

RESERVED FOR MEDICAL PERSONNEL

REQUIRES ADDITIONAL MEDICAL ADVICE
Yes ❑ No ❑
Signature of first prescriber

SUITABLE FOR VACCINATION
Yes ❑ No ❑
Doctor name

MONITORING TIME
15 min ❑ 30 min ❑
Docture Signature

INJECTION ARM
LEFT ❑
RIGH ❑

N° DE LOT :

N° Box

Nurse NAME - signature

EXIT TIME : H

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