

Name and surname of the patient:

PESEL or passport number:

Intake screening interview before vaccinating an adult against COVID-19

The questionnaire should be completed before visiting a doctor. Answering the following questions will help your doctor decide if you can be immunized against COVID-19 today. Your answers will be used by your doctor when qualifying for vaccination. The doctor may ask additional questions. In case of uncertainty, ask the healthcare professional responsible for the vaccination for clarification.

No.	Initial questions	Yes	No
1.	Have you had a positive genetic or antigen test for SARS-CoV-2 in the last 4 weeks?		
2.	In the last 14 days, have you had any close contact or live with a person who was tested positive for the SARS-CoV-2 genetic or antigen test or live with a person who had symptoms of COVID -19 during this period? (listed in questions 3–5)?		
3.	Have you had an increased body temperature or fever in the last 14 days?		
4.	Have you had a new, persistent cough or increased of chronic cough due to a recognized chronic disease in the last 14 days?		
5.	In the last 14 days, have you experienced a loss of sense of smell or taste?		
6.	Have you returned from abroad in the last 14 days (red zone)?		
7.	Have you received any vaccine in the last 14 days?		
8.	Do you have a cold or diarrhea or vomiting today?		

If the answer to any of the above questions is positive, vaccination against COVID-19 should be postponed. You should come to the vaccination when all answers to the above-mentioned the questions will be negative. In case of doubt, please contact the vaccinating physician.

No.	Questions on health condition	Yes ^a	No	I don't know ^a
1.	Do you feel sick today, is there any aggravation (exacerbation) of your chronic disease?			
2.	In the past, has your doctor diagnosed you with a severe, generalized allergic reaction (anaphylactic shock) after administration of any medicine or food, or after an insect bite?			
3.	Have you ever had a severe adverse reaction after vaccination?			
4.	Has your doctor ever diagnosed you with an allergy to polyethylene glycol (PEG) or other substances ¹ ?			
5.	Do you suffer from a disease that significantly lowers immunity (cancer, leukemia, AIDS or other diseases of the immune system)?			
6.	Do you receive immunosuppressive drugs, e.g. cortisone, prednisone or other corticosteroids (dexamethasone, Encortolone, Encorton, hydrocortisone, Medrol, Metypred, etc.), anti-cancer drugs (cytostatic drugs), post-transplant drugs organ, radiation therapy (irradiation) or treatment for arthritis, inflammatory bowel disease (eg Crohn's disease) or psoriasis?			
7.	Do you suffer from hemophilia or other serious bleeding disorders? Do you receive anticoagulants?			
8.	<i>(only for ladies)</i> Are you pregnant?			
9.	<i>(for ladies only)</i> Do you breastfeed your baby?			
10.	Do you have any doubts about the questions asked? Were any of the questions unclear?			

^a Answer YES or DON'T know, to any question requires additional clarification by the doctor.

Form filled in by: Date:

Form checked by: Date:

Declaration

I declare that I voluntarily consent to vaccination against COVID-19.

I confirm that I have been provided with the information regarding this vaccination and that I understand it. I was also provided with answered to all the questions I asked and I understood / understand the answers given to me.

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Date and signature

¹ More information about the composition of the vaccine can be found in the Package Leaflet, available at urpl.gov.pl. Leaflet provides vaccination personnel.