Declaration of consent to having the flu (influenza) vaccination:

☐ Flu (influenza) inactive tetravalent normal dose vaccine

☐ Flu (influenza) inactive tetravalent high dose vaccine

Surname, First name: _____

born on: _____

We ask you to provide the following information on your health condition, so that the doctor can decide if you can be vaccinated today effectively and without particular danger:

Signs of an acute illness (e.g. a feverish cold):

□ no □ yes, the following: _____

Severe chronic illnesses (also including seizures):

□ no □ yes, the following: _____

Have you taken medicines or treatments within the last three months that have a strong effect on the immune system? e.g. cortisone, gamma globulins, immune suppressants:

□ no □ yes, the following: _____

Do you take blood-thinning medication? e.g. Marcumar, Falithrom, heparin:

□ no □ yes, the following: _____

Do you have any allergies? e.g. against egg protein, antibiotics, others:

□ no □ yes, the following: _____

Any previous vaccination side effects? (e.g. allergic reactions, high fever)

□ no □ yes, the following: _____

Other vaccinations received in the previous 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, however, we are obliged to inform you about all side effects that have ever occurred.
Every vaccination can produce local reactions at the injection site such as pain, redness, swelling and hardening. The vaccination intended for you is marked on this declaration of consent. Please read the information from the enclosed vaccination consent form carefully before the vaccination.
I hereby declare that I have read and understood the information. It was also explained to me that STIKO recommends the tetravalent high dose vaccination for patients over 60 years of age, but that I can also be vaccinated with another tetravalent vaccine. I have read the information sheet "Information about the influenza ("flu") vaccination with quadruple vaccine (tetravalent vaccine)" and had the opportunity to receive further information in the consultation.
There was sufficient opportunity to ask questions. I agree to have the vaccination with the vaccine mentioned above.

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

Place, date: **Signature:**

Optional detail:

Date of vaccination _____ Batch sticker

Place of vaccination – upper arm: left □ right □ sc □ i.m. □

Stamp/signature doctor_____