HEALTHCARE PROVIDER (insert as appropriate) Oravská poliklinika Námestovo

Advice and patient's written informed consent pursuant to Act No. 576/2004 Coll. on healthcare, healthcare related services and on amendments to certain acts as amended

First name and surname of the person who is to receive health care	
Birth number	
Residence (street name and number, municipality, postal code)	
Phone number /email (for contacting the patient if medical examination needs to be completed)	

Newly onset medical conditions or symptoms and other medical history information

.....

.....

Proposed (planned) preventive procedure:

The vaccine is given in two doses for a double-dose vaccination scheme, or in one dose for a single-dose vaccination scheme. The vaccine can be a viral protein, an attenuated virus eliciting the creation of a viral protein for a short time, mRNA – non-nuclear RNA coding for a viral protein. Vaccination can be described as introducing the virus to the patient's immunity system, thus eliciting the formation of antibodies and initiating other mechanisms for subsequent protection against the development of the disease.

An additional third dose for immunocompromised persons is part of the basic vaccination scheme and is given by administering mRNA vaccines. For other persons, a booster shot of the vaccine against COVID-19 can be administered no earlier than 3 months after completing the double-dose vaccination scheme or, in the case of a single-dose vaccination scheme, no earlier than 8 weeks after administering the basic vaccination scheme.

I, the undersigned,.....
hereby certify that I have been informed about the nature of the proposed diagnostic procedure which I will undergo for prevention purposes, as well as about its possible consequences and risks (side effects of the vaccine are published in the Package leaflet: Information for the user, which can be found on the website www.sukl.sk and at the premises of the workplace ..... (insert the vaccination point).

I have also been advised of the options available in terms of the proposed procedures and the risks associated with their rejection. The advice has been provided to me in a comprehensible and respectful manner, under no duress and with the possibility and ample time to decide freely. I have understood the advice.

I hereby also confirm that I have been informed about the possible contra-indications related to the administration of the vaccine, such as hypersensitivity to an ingredient of the vaccine or an acute febrile illness. More information about the vaccine can be found in the Package leaflet: Information for the user, which can be obtained on the website www.sukl.sk and at the premises of the workplace ..... (insert the vaccination point).

I, the undersigned, hereby certify that **I GIVE / DO NOT GIVE MY CONSENT**[1] to the proposed preventive procedure. I am giving this consent of my own free and solemn will and in full awareness.

If the preventive procedures as proposed above cannot be provided at ..... (insert the vaccination point) for capacity reasons without undue delay, I hereby declare that, despite the possibility to undergo the above procedures in other medical facilities, I insist on receiving the above procedure at ..... (insert the vaccination point) and I am prepared to wait until the date scheduled for me.

In (place) ..... on (date) ..... at (time) .....

....

Physician's signature and stamp

Signature of the person receiving health care/legal guardian

[1] strike out as appropriate

MINISTRY OF HEALTH OF THE SLOVAK REPUBLIC	MEDICAL HISTORY QUESTIONNAIRE FOR THE PATIENT
Oravská poliklinika Námestovo*, Červeného kríža 62/30, 029 01 Námestovo*	

PATIENT'S IDENTIFICATION DATA		
First name:	Surname:	Birth number:
Vaccine administration date and time:		

MEDICAL HISTORY QUESTIONS FOR THE PATIENT		
QUESTION	**YES**	**NO**
Do you have any symptoms of an acute illness (temperature above 37°C, productive cough, cough with mucus, weakness, joint and muscle pain, malaise, infectious diarrhoea, sore throat)?		
Are you suffering from a severe illness that was evaluated in the past as a possible obstacle (contra-indication) for administering the vaccine (e.g. autoimmune disease, demyelinating disease)?		
Have you had a severe allergic reaction in the past (e.g. anaphylactic shock)?		
Have you had severe side effects following vaccination in the past?		
Are you suffering from severe blood clotting disorder (e.g. severe form of haemophilia)?		
Are you pregnant?		

Date:	Signature of the vaccinated person:
Date:	Signature of the health worker–vaccinator:

Annex 3