OGÓLNOPOLSKI PROGRAM ZWALCZANIA GRYPY

Koalicja na rzecz szczepień w aptekach

Stamp and designation of medical facility

Patient's first and last name: _____

PESEL (Polish resident identification number) or passport series and number: _____

Phone number: _____

Person authorised to contact on health matters _____

Questionnaire for initial screening interview before adult influenza vaccination

It is a good idea to fill out the questionnaire before visiting the vaccination centre.

Answering the following questions will allow the vaccine qualification personnel to decide whether you can be safely vaccinated against influenza In case of ambiguity, ask for clarification.

No.	Initial questions regarding exposure to COVID-19	YES	NO
1.	Have you had a positive genetic or antigen test within the last 14 days for SARS-CoV-2 infection?	o	o
2.	In the past 14 days, have you been in close contact or do you live with a person who has had a positive genetic or antigen test result for SARS-CoV-2 infection, or lives with a person, who had COVID-19 symptoms during this period (as listed in questions 3–5)?	o	o
3.	Have you had an increased body temperature or fever in the past 14 days?	o	o
4.	Have you experienced a new persistent cough or increased chronic cough due to a diagnosed chronic disease in the last 14 days?	o	o
5.	Have you experienced loss of smell or taste sensation or profuse night sweats in the past 14 days?	o	o
6.	Do you feel cold or experience diarrhoea or vomiting today?	o	o

If the answer to any of the above questions is YES (positive), the flu vaccination can be postponed. You should attend the vaccination when all answers are NO (negative). If in doubt, contact the vaccination centre by phone.

Interview questionnaire before adult influenza vaccination

No.	Health-related questions	YES[a]	NO	I DON'T KNOW[a]
1.	Do you feel sick today?	o	o	
2.	Have you ever had a severe adverse reaction after vaccination, including influenza? If so, which one? _____	o	o	o
3.	Have you been diagnosed with an allergy to egg (ovalbumin, chicken protein), neomycin, formaldehyde, octoxynol-9 or to other substances included in the vaccine[1]?	o	o	o
4.	Have you been diagnosed with a severe, generalised allergic reaction (anaphylactic shock) in the past, after a vaccination, food, drug administration or insect bite?	o	o	o
5.	Are you currently experiencing an exacerbation of a chronic disease?			o
6.	Does your disease (e.g., HIV infection, leukaemia, cancer, lack of spleen) or medication you are taking lower your immunity? E.g. immunosuppressants, corticosteroids, cytostatics, transplant anti-rejection drugs, radiation therapy (irradiation), or biologic treatment	o	o	o
		o	o	o

[1] For more information on the composition of flu vaccines, see the Patient Leaflet available at The leaflet is also made available to personnel who carry out vaccinations.

Interview questionnaire before adult influenza vaccination - continued

No.	Health-related questions	YES[a]	NO	I DON'T KNOW[a]
7.	Do you suffer from haemophilia or other serious clotting disorders?	○	○	○
8.	Have you ever been vaccinated against influenza?	○	○	○
9.	Have you ever lost consciousness after a vaccination or other medical procedure?	○	○	○
10.	Have you experienced Guillain-Barre disease?	○	○	○
11.	(Ladies only) Are you pregnant or breastfeeding?	○	○	○

[a] An answer of YES or NO to either question requires clarification by the staff qualifying the vaccination.
A YES answer to any of questions 2-8 regarding health status is an indication of qualification by a physician.

No.	Questions at the vaccination site	YES	NO
1.	Do you have any doubts about the questions asked?	○	○
2.	Did you get the answers to the questions you asked?	○	○

Statement

I certify that I have completed the questionnaire to the best of my knowledge and voluntarily consent to the flu vaccination. I confirm that sufficient information regarding this vaccination has been provided to me and I have understood it. I received answers to all the questions I asked and understood the answers given to me.

_____

Date and legible signature

Qualified for vaccination/not qualified for vaccination (underline) as appropriate, by:

_____ _____

(legible signature of the qualifying person) Date / time

Information about vaccination _____

Name of vaccine/manufacturer _____

Lot number _____

Use-by-date _____

Injection site: Right arm ○ Left arm ○

Notes:

_____

_____

_____

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