



Place for pharmacy designation

Patient's forename and surname:

PESEL or document series and number:

Date of birth: Date of filling in the questionnaire

Contact telephone number:

A screening survey questionnaire prior to vaccination against tetanus, diphtheria, pertussis and *poliomyelitis*

To be filled in **before a visit** at the vaccination clinic.

Answers to the questions below will facilitate qualification for vaccination against tetanus, diphtheria and pertussis, or against tetanus, diphtheria, pertussis (and *poliomyelitis*). Should anything be unclear, feel free to ask the qualifying person for explanations.

Part I: Medical history

No.	Questions on the state of health	YES ^a	NO	I DON'T KNOW ^a
1.	Does the person being qualified for vaccination feel sick today? (If yes, body temperature measurement at the vaccination clinic: °C)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	Has the person being qualified for vaccination ever had a severe adverse reaction after vaccination? If yes, what kind? How soon after the vaccination? What vaccine was administered?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	Has the person being qualified for vaccination been diagnosed with allergy to substances contained in the vaccine ¹ , including phenoxyethanol, formaldehyde and glutaraldehyde? (see leaflet)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	Was the person being qualified for vaccination previously diagnosed with Guillain-Barre syndrome within 6 weeks after administration of a vaccine containing tetanus toxoid?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	Was the person being qualified for vaccination diagnosed with severe, generalised allergic reaction (anaphylactic shock) after administration of medication, food, or insect bite in the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	Does the person being qualified for vaccination currently experience exacerbation of a chronic disease?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	Does the person being qualified for vaccination suffer from a neurological disease, uncontrolled epilepsy or progressive encephalopathy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	Does the person being qualified for vaccination receive medication lowering immunity (immunosuppressants, oral corticosteroids, e.g. prednisone, dexamethasone), medication due to malignant neoplasm (cytostatics), medication after stem cell or organ transplantation, radiation therapy (radiotherapy) or biological treatment due to arthritis, inflammatory bowel disease (e.g. Crohn's disease) or psoriasis? Does the person being qualified suffer from immunodeficiency?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

No.	Questions on the state of health	YES ^a	NO	I DON'T KNOW ^a
9.	Does the person being qualified for vaccination have haemophilia or other serious coagulation disorders?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	Is the person being qualified for vaccination pregnant or can she be pregnant (how many weeks)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

¹ More information on the vaccination composition can be found in the package leaflet available on the website. The leaflet is also provided by the personnel administering vaccination.

^a The answer YES or I DON'T KNOW to any of the questions requires additional explanation by the person qualifying for vaccination. _____

Was the patient vaccinated against tetanus, diphtheria, pertussis or *poliomyelitis* in the past?

YES When was the last dose administered?

NO

No.	Questions at the vaccination clinic	YES	NO
1.	Have any doubts developed regarding the questions asked?	<input type="radio"/>	<input type="radio"/>
2.	Have the questions asked been answered?	<input type="radio"/>	<input type="radio"/>

Part II: Pharmacist's assessment

Qualification for vaccination

YES

NO Please state reason

Post-vaccination instructions

 (stamp and signature of the person qualifying for vaccination)

 Date / time

Part III: Consent to vaccination

Statement

I declare that I have read the information on vaccination against tetanus, diphtheria and pertussis (and *poliomyelitis*), and that the above answers are truthful. I consent to the vaccination.

 (signature of the patient/legal guardian)

 Date