

Space for the designation of medical provider

Patient's full name: PESEL or passport series and number:

Statutory representative's full name:

Contact details (address and telephone number):

COVID-19 pre-vaccination screening form for minors (to be completed before visiting the vaccination site)

The following questions will help the screening staff to determine whether the patient is eligible to be vaccinated against COVID-19 today. The answers will be used in making the decision whether they are eligible for vaccination. The screening staff may ask additional questions. If you have any doubts, please ask the screening staff or vaccinator for clarification. **Patients under the age of 15 are screened by medical practitioners.**

| No. | Pre-screening questions concerning exposure to COVID-19 | Yes | No |
|-----|--|-----|----|
| 1. | Has the patient had close contact or been living with someone who took a genetic or antigen test for SARS-CoV-2 and tested positive in the last seven days, or has the patient been living with a person experiencing COVID-19 symptoms (listed under Questions 2-4) within that period? | | |
| 2. | Has the patient experienced higher body temperature or a fever in the last seven days? | | |
| 3. | Has the patient been experiencing a sore throat, a new continuous, cough or a worsening chronic cough due to a diagnosed chronic condition in the last seven days? | | |
| 4. | Has the patient lost their sense of smell or taste in the last seven days? | | |
| 5. | Is the patient experiencing today a cold, diarrhoea or vomiting? | | |

If you answered YES (affirmative) to any of these questions, the patient's COVID-19 vaccination should be delayed. Please come back for the vaccination appointment only when you can answer NO (negative) to all questions. If you have any doubts, please contact the vaccination site.

COVID-19 pre-vaccination medical history form for minors

| No. | Health questions | Yes ^a | No | Don't know ^a |
|-----|--|------------------|----|-------------------------|
| | Is the patient feeling unwell today? (body temperature at vaccination site:°C) | | | |
| | Has the patient ever experienced a serious adverse reaction following vaccination (including following the first dose of a COVID-19 vaccine)? If so, what was the reaction? | | | |
| | Has the patient been diagnosed as allergic to polyethylene glycol (PEG), polysorbate, or other vaccine components ¹ ? | | | |
| | Has the patient been diagnosed with a severe generalised allergic reaction (anaphylactic shock) after drug intake, food consumption, or insect bite? | | | |
| | Is the patient experiencing an exacerbated chronic condition? | | | |

¹For more information on COVID-19 vaccine components, please consult the patient leaflet available at the "Szczepimy się" website, <https://www.gov.pl/web/szczepimysie/materialy-informacyjne-dla-szpitali-i-pacjentow-dotyczace-szczepien-przeciw-covid-19>. You can also get the leaflet from your vaccinator.

| No. | Health questions | Yes ^a | No | Don't know ^a |
|-----|--|------------------|----|-------------------------|
| | Is the patient taking medication that weakens their immune system (immunosuppressants, oral corticosteroids, e.g. prednisone or dexamethasone), (cytostatic) drugs for malignant tumours or post-transplant medication, or is the patient undergoing radiation therapy or biological therapy for arthritis, inflammatory bowel disease (such as Crohn's disease) or psoriasis? | | | |
| | Does the patient suffer from haemophilia or other serious blood clotting disorder? | | | |
| | Has the patient been diagnosed with heparin-induced thrombocytopenia (HIT) or cerebral venous sinus thrombosis? | | | |
| | (For women only) Is the patient pregnant? | | | |
| | (For women only) Is the patient breastfeeding? | | | |

a) If you answered YES or DON'T KNOW to any of the questions, screening staff will have to ask you for additional clarification. If you answered YES to any of the health questions 2-8, this indicates that the patient should be screened by a medical practitioner. **Patients under the age of 15 are screened by medical practitioners.**

| No. | Questions at the vaccination site | Yes | No |
|-----|--|-----|----|
| 1. | Do you have any doubts concerning the questions asked? | | |
| 2. | Have you received answers to your questions? | | |

Deemed eligible for vaccination / not eligible for vaccination (underline as appropriate) by:

..... Date:/ Time:
(legible signature of screening staff)

***Consent**

I voluntarily give my consent to be vaccinated against COVID-19. I confirm that I have received and understood information about this vaccination. I have also received and understood answers to all questions I asked.

.....
Date and legible signature
(*signature required if the patient is above 16 years old)

Consent of the statutory representative

I,,
(full name/ address)

declare that I am a statutory representative of:

....., born on, PESEL number:
....., Sex: W.....M.....

(full name/date of birth/PESEL of the minor or, in the case of no PESEL No., the type, series and No. of an identification document, Sex)

and give consent for them to be vaccinated against COVID-19 on:,

.....
Date and legible signature
(signature of the statutory representative)