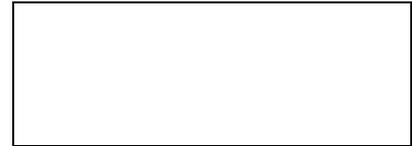




POLISH NATIONAL  
PROGRAMME OF  
FIGHTING INFECTIOUS  
DISEASES



**Coalition for  
vaccination in  
pharmacies**



Stamp and name of medical facility

Patient's full name: \_\_\_\_\_

PESEL or passport series and number: \_\_\_\_\_

Contact telephone: \_\_\_\_\_

Person authorised to contact in health matters \_\_\_\_\_

## Initial screening questionnaire before vaccination of an adult against pneumococci

The questionnaire should be completed before a visit at the vaccination clinic.

Answers to the questions below will enable the qualifying staff to decide if you can be safely vaccinated against pneumococci. Should anything be unclear, feel free to ask for explanations.

No.	Preliminary questions regarding exposure to COVID-19	YES	NO
1.	Have you had a positive result of a genetic or antigen test for SARS-CoV-2 infection in the last 14 days?	<input type="radio"/>	<input type="radio"/>
2.	Have you had a close contact in the last 14 days, or do you live with a person who had a positive result of a genetic or antigen test for SARS-CoV-2 infection, or do you live with a person who had COVID-19 symptoms in this period (specified in questions 3–5)?	<input type="radio"/>	<input type="radio"/>
3.	Have you had an increased body temperature or fever in the last 14 days?	<input type="radio"/>	<input type="radio"/>
4.	Have you had new persisting cough or more severe chronic cough due to a diagnosed chronic disease in the last 14 days?	<input type="radio"/>	<input type="radio"/>
5.	Do you have a cold, diarrhoea, vomiting today?	<input type="radio"/>	<input type="radio"/>

If you answer YES (positive) to any of the above questions, vaccination against influenza may be postponed. You should come in for vaccination when all the answers are NO (negative). Should you have any doubts, contact the vaccination clinic by telephone.

## History-taking questionnaire before vaccination of an adult against pneumococci

No.	Questions on the state of health	YES	NO
1.	Do you feel sick today?	<input type="radio"/>	<input type="radio"/>
2.	Have you ever had a severe adverse reaction after vaccination? If yes, what kind? _____	<input type="radio"/>	<input type="radio"/>
3.	Were you diagnosed with severe, generalised allergic reaction (anaphylactic shock) after vaccination, food, medication or insect bite in the past?	<input type="radio"/>	<input type="radio"/>
4.	Do you currently experience exacerbation of a chronic disease?	<input type="radio"/>	<input type="radio"/>
5.	Does your disease (e.g. HIV infection, leukaemia, cancer, asplenia) or medication taken compromise your immunity? E.g. immunosuppressive drugs, corticosteroids, cytostatics, agents preventing graft rejection, radiotherapy or biological treatment.	<input type="radio"/>	<input type="radio"/>

## History-taking questionnaire before vaccination of an adult against pneumococci, continued

No.	Questions on the state of health	YES <sup>a</sup>	NO	I DON'T KNOW <sup>a</sup>
6.	Do you have haemophilia or other serious coagulation disorders?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	Have you ever been vaccinated against pneumococci?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	Have you ever lost consciousness after vaccination or other medical procedure?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<sup>a</sup> The answer YES or I DON'T KNOW to any of the questions requires explanation by the staff qualifying for vaccination. The answer YES to any of the questions 2-8 on the state of health is an indication for performing qualification by a doctor.

No.	Questions at the site of vaccination	YES	NO
1.	Do you have any doubts regarding the questions asked?	<input type="radio"/>	<input type="radio"/>
2.	Have you received answers to your questions?		

### Declaration

I declare that I have completed the questionnaire to the best of my knowledge and I give my voluntary consent to be vaccinated against pneumococci. I confirm that I have been provided with sufficient information on this vaccination and I have understood it. I have received answers to all my questions and I have understood the answers provided.

\_\_\_\_\_  
Date and legible signature

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

\_\_\_\_\_  
(legible signature of the qualifying person)

\_\_\_\_\_  
Date / time

Information on vaccination \_\_\_\_\_

Vaccine name/manufacturer \_\_\_\_\_

Batch number \_\_\_\_\_

Expiry date \_\_\_\_\_

Injection site:             Right arm    Left arm

Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_