OGÓLNOPOLSKI PROGRAM
ZWALCZANIA CHORÓB INFEKCYJNYCH

Koalicja na rzecz
szczepień w aptekach

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 <u>before a visit</u> 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)	○	○	○
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?	○	○	○
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)	○	○	○
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?	○	○	○
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?	○	○	○
6.	Does the person being qualified for vaccination currently experience exacerbation of a chronic disease?	○	○	○
7.	Does the person being qualified for vaccination suffer from a neurological disease, uncontrolled epilepsy or progressive encephalopathy?	○	○	○
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?	○	○	○

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?	○	○	○
10.	Is the person being qualified for vaccination pregnant or can she be pregnant (how many weeks)?	○	○	○

[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?	○	○
2.	Have the questions asked been answered?	○	○

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

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