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: _____ Age at the time of qualification: _____

Contact telephone number: _____ Date of filling in the questionnaire: _____

Initial screening questionnaire prior to vaccination of an adult against tick-borne encephalitis virus

To be **filled in <u>before a visit</u> at the vaccination clinic**.

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

Part I: Medical history

No.	Questions on the state of health	YES	NO
1.	Do you feel sick today?	○	○
2.	Do you have a chronic disease, e.g. rheumatoid arthritis, blood disease, leukaemia, HIV infection, neoplastic disease, asplenia?	○ what kind ? _____	○
3.	Do you currently experience exacerbation of a chronic disease?	○ what kind ? _____	○
4.	Do you take regular medications?	○ what kind ? _____	○
5.	Does your disease or medication taken compromise your immunity? E.g. immunosuppressive drugs, corticosteroids, cytostatics, agents preventing graft rejection, radiotherapy or biological treatment.	○ what kind ? _____	○
6.	Do you have haemophilia or other serious coagulation disorders?	○ what kind ? _____	○
7.	Have you ever had a severe adverse reaction after vaccination?	○ what kind ? _____	○
8.	Were you diagnosed with severe, generalised allergic reaction (anaphylactic shock) after vaccination, food, medication or insect bite in the past?	○ please describe _____ _____	○
9.	Have you ever lost consciousness after vaccination or other medical procedure?	○	○

No.	Questions regarding tick-borne encephalitis and vaccination against tick-borne encephalitis virus	YES	NO
1.	Have you ever had tick-borne encephalitis or meningitis?*	○ when? _____	○
2.	Have you ever been vaccinated against tick-borne encephalitis?**	○ when? _____	○

Part II: Assessment of a healthcare professional qualifying for vaccination

Qualification for vaccination

YES ○

NO ○ Please state reason for postponing

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 tick-borne encephalitis (TBE), and that the above answers are truthful. I consent to the vaccination.

_____ _____

(signature of the patient/legal guardian) Date

* Past tick-borne encephalitis ensures immunity; vaccination is safe but not required

** Knowledge on received vaccination against TBE enables to establish the number of required doses of the vaccine

Preparation and consultation: **Ernest Kuchar, MD, PhD**