CENTRE DE VACCINATION DU BEAUVAISIS

COVID-19

First injection

PFIZER

[1]

COVID-19 VACCINATION FILE

NAME :

SURNAME :

BIRTH DATE : / /

We thank you :

- Bring the prescription of your current medical prescriptions
- Show up at the time of your appointment, not in advance
- Respect physical distancing and barrier gestures

Do you have a certificate from your treating physician to be vaccinated against COVID-19	Yes ❑ No ❑
Did you have COVID-19 ? If Yes when ?	Yes ❑ No ❑
Have you been in contact with a COVID-19 person in the past 14 days ? (fever, cough, loss of smell and taste...)	Yes ❑ No ❑
If yes Have you been tested ?	Yes ❑ No ❑
Do you have a fever right now ?	Yes ❑ No ❑
Have you received a vaccine in the past two weeks ? If yes which one ?	Yes ❑ No ❑
Do you had severe allergy or hypersensitivity to certain substances or with other vaccines? If yes which one ?	Yes ❑ No ❑
Do you have anticoagulant or thinning treatment?	Yes ❑ No ❑
Do you have any coagulation disorders (low platelet levels...) ?	Yes ❑ No ❑
Are you less than 3 months pregnant?	Yes ❑ No ❑
Are you on immunosuppressive therapy (chemotherapy, immunotherapy, targeted therapy, HIV infection), anti-monoclonal treatment (anti-CD19, anti-CD20,): ex Rituximab...	Yes ❑ No ❑
Additional comment	

REQUEST FOR INFORMED CONSENT

❑ I acknowledge that I have received the information, including the terms of this questionnaire, that I have answered it in all sincerity and I wish to be vaccinated.

Patient Date and Signature :

The / /

RESERVED FOR MEDICAL PERSONNEL

REQUIRES ADDITIONAL MEDICAL ADVICE

Yes ❑ No ❑

Signature of first prescriber

SUITABLE FOR VACCINATION

Yes ❑ No ❑

Doctor name

MONITORING TIME

15 min ❑ 30 min ❑

Docture Signature

INJECTION ARM

LEFT ❑

RIGH ❑

N° DE LOT :

N° Box

Nurse NAME - signature

EXIT TIME : H

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PRÉFÈTE DE L'OISE Liberté Égalité Fraternité

CHB Centre Hospitalier de Beauvais

ars Agence Régionale de Santé Hauts-de-France

Beauvais CŒUR DE L'OISE, CŒUR DE VIE !

Agglo du Beauvaisis