No.	Questions - health related	YES	No Don't Know
1.	Do you feel sick today, is there any aggravation (exacerbation) of your chronic disease?		
2.	Is in the past, has a doctor diagnosed you with a severe, generalized allergic reaction (anaphylactic shock) after giving some medicine or food, or after being bitten by an insect?		
3.	Have you ever experienced severe undesirable effects? reaction after vaccination?		
4.	Is has a doctor ever diagnosed you allergic to polyethylene glycol (PEG) or other substances?		
5.	Is do you suffer from a disease that significantly reduces your immunity (cancer, leukemia, AIDS or other diseases of the immune system)?		
6.	Is you are receiving drugs that suppress your immunity (immunosuppressants), e.g. cortisone, prednisone or another corticosteroid (dexamethasone, Encortolone, Encorton, hydrocortisone, Medrol, Metypred, etc..anti-cancer drugs (cytostatic), drugs taken after organ transplants, radiotherapyandę (irradiation) or treatment for arthritis, inflammatory bowel disease (e.g. Crohn's disease) or psoriasis?		
7.	Do you have hemophilia or other serious bleeding disorders? Do you receive anticoagulants?		
8.	*(only for women)* Are you pregnant?		
9.	*(only for women)* Do you breastfeed your baby?		
10.	Do you have any doubts about the questions asked? Were any of the questions unclear?		

Answering YES or DON'T know, to any question requires additional clarification by the doctor.

Form completed by: .... Date: ....

Form checked by: .... Date: ....

Statement

I declare that I voluntarily consent to vaccination against COVID-19

I confirm that I have been provided with the information regarding this vaccination and that I understand it. I was also answered to all the questions I asked and I understood / understand the answers given to me.

date and signature

[1] More info about this can be found in Leaflet for the patient, available on the website urpl.gov.pl. This leaflet is available from vaccination staff.