

**DECLARATION OF CONSENT  
FOR VACCINATIONS**



TRAVEL DESTINATION: \_\_\_\_\_

**QUESTIONS ABOUT THE HEALTH SITUATION**

**Please fill out in block letters clearly legible and completely!**

**Data of the person to be vaccinated**

Please tick appropriate box!

<b>name:</b>	<b>first name:</b>	<b>date of birth:</b>
<b>Ev. birth name:</b>	<b>social insurance number:</b>	
male: <input type="checkbox"/>	female: <input type="checkbox"/>	
<b>adress:</b>		
<b>e-mail:</b>	<b>phone:</b>	
<b>name of legal guardian:</b>		

1. **Do you currently have an acute illness/fever??**  yes  no
  2. Do you have an acquired or congenital immune deficiency/immune disease (e.g. cancer, leukemia, HIV-AIDS, hepatitis C, renal failure (dialysis), autoimmune disease)?  
Intolerance against Phenylketonuria (PKU)?  
If yes, which? \_\_\_\_\_  yes  no
  3. Is there a tendency to bleed (tendency to bruise?) or coagulation disorder or reduced platelet count? (e.g. after an MMR vaccination)  yes  no
  4. Do you have a chronic or progressive disease, especially of the brain (e.g. epilepsy) and spinal cord / nerve inflammation, muscle weakness, liver, kidneys or an autoimmune disease? (e.g. paralysis, nerve inflammation, multiple sclerosis, thymus disease, rheumatoid arthritis, tuberculosis)  
If yes, which? \_\_\_\_\_  yes  no
  5. Did you receive blood, blood products or immunoglobulins (e.g. a passive vaccination) in the last 3 months? If yes, when and what? \_\_\_\_\_  yes  no
  6. Did you receive another vaccination in the last 4 weeks?  
If yes, which? \_\_\_\_\_  yes  no
  7. Did you have a disease/infection or surgery within the last 4 weeks?  
If yes, which? \_\_\_\_\_  yes  no
  8. Do you have an allergy/allergy reaction (e.g. to vaccine components, to **latex, yeast, rubber**, eculizumab, formaldehyde, protamine sulfate, chlortetracycline, amphotericin B, polygelin, kanamycin, neomycin (sulfate), gentamycin, sorbitol, octoxynol-9, streptomycin, polymyxin B, glycine, glutaraldehyde, eggs or chicken **protein, casein**), para-aminobenzoic acid?  
If yes, which? \_\_\_\_\_  yes  no
  9. Does a serious reaction (e.g. brain dysfunction) fainting / allergic reaction / febrile spasm /GBS (ascending paralysis) to a vaccination be known?  
If so, which one, with which vaccination? \_\_\_\_\_  yes  no
  10. Do you regularly take **medication** such as cortisone, or Infliximab or other immunosuppressive drugs (e.g. after transplantation or cancer therapy) or blood thinning (e.g. Sintrom)?  
**If yes, which and when?** \_\_\_\_\_  yes  no
  11. Is a tuberculosis test planned?  yes  no
  12. **For women:** Are you planning a pregnancy, are you pregnant or breastfeeding?  
**Breastfeeding mothers must stopp feeding for 2 weeks after yellow fever vaccination. I acknowledge that I should not become pregnant until 1 month after a measles mumps rubella vaccination or yellow fever vaccination.**  yes  no
- I agree with the data proccession. (DSGV - information sheet is laid out)  yes  no

**Please turn – sign after clarification!**

TRAVEL DESTINATION: \_\_\_\_\_

travel start: \_\_\_\_\_ duration: \_\_\_\_\_  
art: fancy/hotel  yes adventure  yes Malaria-Prophylaxe required:  yes  no

arranged VACCINATIONS:				
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I have been sufficiently informed about the benefits and risks of the vaccinations and have had the opportunity to discuss Questions to be discussed with the vaccinator..  yes  no

I agree to the above mentioned vaccinations.  yes  no

date: \_\_\_\_\_ Signature of the person to be vaccinated/the legal guardian for persons under 14 years of age ren \_\_\_\_\_

**To be further registered by the vaccinator:**

Vaccination against : \_\_\_\_\_  Please tick the appropriate box

<input type="checkbox"/> Refresher vaccination <input type="checkbox"/> 1. part vaccination basic immunisation (BI) <input type="checkbox"/> 2. part vaccination BI <input type="checkbox"/> 3. part vaccination BI	batch number
vaccine : _____ Chargen-Nr. _____	

There are no further questions

Vaccination against: \_\_\_\_\_

<input type="checkbox"/> Refresher vaccination <input type="checkbox"/> 1. part vaccination (BI) <input type="checkbox"/> 2. part vaccination BI <input type="checkbox"/> 3. part vaccination BI	batch number
vaccine : _____ Chargen-Nr. _____	

There are no further questions

Vaccination against: \_\_\_\_\_

<input type="checkbox"/> Refresher vaccination <input type="checkbox"/> 1. part vaccination (BI) <input type="checkbox"/> 2. part vaccination BI <input type="checkbox"/> 3. part vaccination BI	batch number
vaccine : _____ Chargen-Nr. _____	

There are no further questions

Vaccination against: \_\_\_\_\_

<input type="checkbox"/> Refresher vaccination <input type="checkbox"/> 1. part vaccination (BI) <input type="checkbox"/> 2. part vaccination BI <input type="checkbox"/> 3. part vaccination BI	batch number
vaccine : _____ Chargen-Nr. _____	

There are no further questions

**Notes for the vaccinator: (personal talks; information; explanations; facts)**

- |   |   |
|---|---|
| <input type="checkbox"/> Information sheet about mosquito protection measures handed out                    | <input type="checkbox"/> Yellow Fever - weaver handed out |
| <input type="checkbox"/> Recipe handed out for : _____ <input type="checkbox"/> Malaria emergency treatment | <input type="checkbox"/> Malaria Prophylaxe               |
| <input type="checkbox"/> informed about other recommended vaccinations                                      | <input type="checkbox"/> personal vaccination plan:       |

**Further notes:**

\_\_\_\_\_ date \_\_\_\_\_ signature of vaccinator, stemp l \_\_\_\_\_