

Anamnesis sheet
Flu vaccination for employees of
Paderborn University



Please fill out the form and bring it with you to the vaccination.

Name	
First name	

1) Do you have any known allergies (especially to chicken protein, antibiotics, or other vaccine ingredients)?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, which:
2) Have you experienced any adverse or allergic reactions after previous vaccinations?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, which:
3) Do you have any signs of an acute illness (e.g. febrile infection)?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, which:
4) Do you suffer from any chronic disease?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, which:
5) Do you have an immune system disease?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, which:
6) Do you take any medication regularly (especially blood-thinning or immunomodulatory medicine)?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, which:
7) Are you pregnant?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, which trimester:

The recommended vaccinations are usually very well tolerated. For legal reasons we still have to inform you about possible side effects.

Please read the information sheet linked in the e-mail carefully before the vaccination. We would like to mention the possible local and general reactions (e.g. pain, redness, swelling at the injection site, discomfort, fever, headache), possible vascular damage and allergic reactions that can be life-threatening.

I have given all information to the best of my knowledge. I have been informed about possible side effects, I have no further questions and I agree to the flu vaccination.

Place, date

Signature of the person being vaccinated