MINISTÈRE
DES SOLIDARITÉS
ET DE LA SANTÉ

Liberté
Égalité
Fraternité

Vaccin COVID-19
SE VACCINER, SE PROTÉGER

VACCINATION AGAINST COVID-19 QUESTIONNAIRE

Surname: ……...

First name: ……...

Date of birth: ……....

Social security number: ……

Have you had a positive (PCR or antigen) test result in the past three months?	☐ Yes	☐ No
Do you have fever today?	☐ Yes	☐ No
Have you received any vaccine in the past two weeks? If yes, which type: ……..	☐ Yes	☐ No
Have you ever had an allergy or hypersensitivity to any substances or to other vaccines?	☐ Yes	☐ No
Do you have any blood clotting issues? (especially low platelets or treatment with anticoagulant medication)	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you breastfeeding?	☐ Yes	☐ No

In the days and weeks following your vaccination, you can, if needed, report an adverse effect. This will only take about 10 minutes on the portal for reporting adverse health effects: **www.signalement.social-sante.gouv.fr**. You can also speak to your doctor.

The identity details collected using this *questionnaire will be integrated with the "SI Vaccin Covid" personal data processing implemented jointly by the Ministère des Solidarités* et *de la Santé and the Caisse nationale d'assurance maladie. This will be solely for the purpose of organising, monitoring* and *directing Covid-19 vaccination campaigns. For more information on this processing and exercising your rights, please consult the information notices available in your centre. The hard copy of the questionnaire will be stored for three months after the date of your appointment.*

For doctor's use only

Date: ……/……/……

Signature of the doctor:

I hereby acknowledge that I have been informed of the primary principles of the Covid 19 vaccination, of the expected benefits and of the possible risks, and I do here consent to receiving the Covid 19 vaccination.
date / /
Signature

VACCINATION TO PROTECT AGAINST COVID