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 protein)?	If yes, which:	☐ yes	☐ no
2) Did you have any adverse or allergic reactions after previous vaccinations?	If yes, which:	☐ yes	☐ no
3) Do you have any signs of an acute illness (e.g. febrile infection)?	If yes, which:	☐ yes	☐ no
4) Do you suffer from any chronic disease?	If yes, which:	☐ yes	☐ no
5) Do you have an immune system disease?	If yes, which:	☐ yes	☐ no
6) Do you take any medication regularly?	If yes, which:	☐ yes	☐ no
7) Are you pregnant?		☐ yes	☐ no

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**