

PERSONAL MEDICAL SHEET

You must read the Vaccination Patient's Charter and the information statement before completing this questionnaire

**MINOR
(UNDER 18)**

Pre-A(H1N1) 2009 vaccination questionnaire				
Surname:		First name:		
		Date of birth:		
Surname, first name and address of the holders of parental authority:				
Answer all questions by ticking the corresponding boxes on this form.			Answer	
			YES	NO
1	Has he/she been vaccinated against seasonal influenza in the past 3 weeks?			
2	Has he/she had any serious reaction when vaccinated or a contra-indication for a vaccination?			
3	Does he/she have an allergy to egg or chicken proteins, to ovalbumin or to certain drugs? <i>(Do not mention digestive intolerance to eating eggs or chicken meat.)</i>			
4	Does he/she currently have a temperature?			
5	Is he/she currently ill or has he/she recently been ill? <i>(Do not mention common diseases like colds, eczema, etc., but be sure to mention confirmed influenza or suspected influenza.)</i>			
6	Is he/she or has he/she been under special medical supervision?			
7	Is he/she suffering from coagulation problems or taking an anticoagulant?			
8	Has he/she been on a medical treatment for more than 30 days in the past 6 months <i>(aside from contraception)</i> ?			
9	For teenage girls: is she pregnant or does she think she may be pregnant?			

To be completed by the medical officer:

Name of medical officer	Signature of medical officer	Date
Observations:		
Medical prescription (name of vaccine and dose):		

To be completed by the person exercising the parental authority:

- I have read the Vaccination Patient's Charter and the Vaccine Information Statement *(tick the box if your answer is yes)*
- I have been given information on the vaccine and its risks *(tick the box if your answer is yes)*
- I agree to the vaccination of my child *(tick the box if your answer is yes)*
- I do not agree to the vaccination of my child *(tick the box if your answer is yes)*
- If this form is to be signed by one of the holders of parental authority: I certify that the second holder agrees to the vaccination *(tick the box if your answer is yes)*

Surname, first name, date and signature of the holder(s) of parental authority (required):

Vaccination centre	Name of vaccine	Batch number