ANTI-COVID-19 VACCINATON

CONSENT FORM

Name and Surname: …….	
Date of birth: ……	Place of birth: …….
Residence: …… ……	Telephone: …….. ……..
National Health Service Card (if available): N. ……	

I have read, I have received in a language known to me, and I have understood the General Information drafted by the Italian Medicines Agency (AIFA) regarding the "_____" vaccine.

I have informed the doctor of all diseases, current and/ or past, and any treatment I am currently on.

I have had the opportunity to ask questions concerning the vaccine and about my health status, and I have received complete answers, which I have understood.

I have been correctly informed, with words that are clear to me. I have understood the benefits and the risks of the vaccination, how it is performed, and any therapeutic alternatives as well as the consequences should I refuse or forgo completing the vaccination with the second dose, if foreseen.

I am aware that, should any side effect occur, it is my responsibility to inform my doctor immediately and to follow the instructions provided.

I accept to remain in the waiting room for at least 15 minutes after the vaccine is administered to ensure that no immediate side effect occurs.