Seasonal Influenza Vaccination Information and Consent Form

Surname: ........................................ First Name: ........................................ Date of birth: ........................................

Company: ........................................................................................................................................

Health Insurance Provider (full name): ........................................................................................................

What is Influenza?
Influenza is a seasonal viral infection. Transmission typically occurs via respiratory aerosols or
droplets (coughing, sneezing) but can also occur by direct contact (e.g. handshake) and by touching
contaminated objects.
The most common symptoms are the sudden onset of high fever, shivering, headache and muscle
pain, sore throat and dry cough. Less severe and non-symptomatic infections are possible.
Recovery can take days and even weeks. Elderly people and those with certain pre-existing conditions
have a higher risk of complications (particularly pneumonia) and an increased risk of death.

Who should get vaccinated? How often do you need to get vaccinated?
The Ständige Impfkommission (STIKO or Standing Committee on Vaccination) at the Robert-
Koch-Institute recommends the vaccination for certain risk groups while the Sozialministerium
Baden-Württemberg (Ministry of Social Affairs) recommends it for all people.
Since the influenza virus continuously changes, a vaccination should be taken every year with an
updated vaccine, preferably in October or November.

Protection
Protection by the vaccination is not 100%. Young, healthy adults can be protected up to 80%,
depending on the match between the vaccination and the circulating influenza viruses. The
vaccination is generally less efficient in older people. The protection usually starts 2 weeks after
vaccination.

Who should not get vaccinated?
Persons with a known hypersensitivity/allergy to components of the vaccine should not be
vaccinated.
If there is a history of severe side effects due to prior influenza vaccinations, a medical workup needs
to be performed before any further influenza vaccinations are given.
Persons with febrile infections and acute illnesses should only be vaccinated after recovery.

Possible side effects of an influenza vaccination
Local reactions (pain, redness and swelling) of the injection site and cold-like symptoms (fever,
tiredness, headache, muscle- and joint pain) may occur and can last a few days..
Very rarely allergic reactions of the skin and/or the respiratory system occur. In isolated cases severe
allergic reactions (anaphylaxis) can occur. Very rarely vasculitis (inflammation of blood vessels) or a
temporary thrombocytopenia (low levels of blood platelets which are part of the blood clotting system)
can occur. There is a disputed correlation between taking the vaccine and the extremely rare
occurrence of the Guillan-Barré-syndrome (rapid onset muscle weakness).

p.t.o.
1.) Is this your first influenza vaccination? ○ yes ○ no

2.) Did you ever experience allergic reactions, high fever or other unusual reactions due to prior vaccinations (not only influenza vaccinations)? ○ yes ○ no
   If yes, please state details
   ……………………………………………………………………………………………………………..

3.) Do you have any known allergies? ○ yes ○ no
   If yes, please state details
   ……………………………………………………………………………………………………………..

4.) Do you have any chronic illnesses, e.g. blood- or bleeding disorders, chronic infections, immunodeficiency, asthma, diabetes, cancer, kidney or neurological diseases?
   ○ yes ○ no
   If yes, please state details
   ……………………………………………………………………………………………………………..

5.) Do you take regular medication that influence blood clotting (anticoagulants), e.g. ASA/Aspirin, Marcumar, Warfarin, other “blood thinners”?
   ○ yes ○ no
   If yes, please state details
   ……………………………………………………………………………………………………………..

6.) Are you pregnant / possibly pregnant? ○ yes ○ no

7.) Are you currently or have you recently suffered from an acute illness?
   ○ yes ○ no
   If yes, please state details
   ……………………………………………………………………………………………………………..

I, …………………………………………………………….………………, Date of birth ……………………,
carefully have read all of the information in the “seasonal influenza vaccination information and consent form” and had the opportunity to ask the vaccinating doctor further questions and get additional information.

○ I have no further questions

○ I consent to being vaccinated against influenza

○ I took note of the Privacy Policy Relating to Flue (Influenza) Vaccination

For publicly insured persons only („gesetzlich krankenversichert“):
○ I consent to the disclosure of my information (Surname, Name, date of birth, vaccination) to my health insurance company by KIT for the purpose for the reimbursement of vaccination expenses.

Place and Date: ……………………………………………..

…………………………………………. ………………………………………………
Signature of person consenting    Signature of physician

Dokumentation:

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