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	
Date of birth	

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

I have given all information to the best of my knowledge. I have been informed about possible side effects and I agree to a vaccination.

_____ _____

Place, date **Signature of the person being vaccinated**