AUTONOME PROVINZ BOZEN – SÜDTIROL
PROVINCIA AUTONOMA DI BOLZANO – ALTO ADIGE
PROVINZIA AUTONOMA DE BULSAN – SUDTIROL

Südtiroler Sanitätsbetrieb
Azienda Sanitaria dell'Alto Adige
Azienda Sanitera de Sudtirol

SÜDTIROL IMPFT
L'ALTO ADIGE SI VACCINA
SÜDTIROL FEJ LA DLAVEA

Betriebsdirektion
Direzione Aziendale

Anti COVID-19 Vaccination
Consent Form
"Vaccine COVID-19 Janssen"

Name and Surname ____

Place of birth _________________________________ Date of birth ____________________

Residence ___________________________________ Telephone ______________________

National Health Service Card (if available) ____

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 COVID-19 Janssen"

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.

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 forgot 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.

I understood that on the basis of the indications of the national scientific technical committee (in its circular protocol n.26246 of 11.06.2021, respectively n.27471 of 18.06.2021 which provide for the possibility of an exception to the age limit over 60 years) and given the positive opinion of the Ethics Committee (territorially competent), the vaccine can also be administered to people under 60 years of age.

CONSENT

I consent to and authorize the administration of the ***"Vaccine COVID-19 Janssen"***

Date and place ______________________________

____
Signature of the person who is receiving the vaccine or of his/her legal representative

REFUSE

I refuse administration of the ***"Vaccine COVID-19 Janssen"***

Date and place ______________________________

____
Signature of the person who is receiving the vaccine or of his/her legal representative

Health care workers of the vaccination team

1. Doctor

Name and Surname ____

Role ____

I confirm that the vaccine recipient has expressed his/her consent to the vaccine, after having been adequately informed.

____

Signature

2. Doctor or other health care worker

Name and Surname ____

Role ____

I confirm that the vaccine recipient has expressed his/her consent to the vaccine, after having been adequately informed.

____

Signature

The presence of a second health care worker is not indispensable when the vaccine is administered at a doctor's office or center, at the recipient's home, or in the event of a logistical/ organizational crisis.