Place Label Here

If label not available, write Pt. Name, IP No. Age, Sex, Date, Name of Treating Physician

VACCINATION REGISTRATION AND CONSENT FORM

Apollo HOSPITALS

FOR OFFICE USE ONLY:

Token No. _____

Date: _____

Vaccine: ☐ COVISHIELD / ☐ COVAXIN / ☐ OTHER _____

Dose No.: _____

Please Mention Beneficiary ID (as received after registration on CoWin): _____

REGISTRATION FORM:

Please fill the registration form given in this section only if you are not registered with Apollo Hospitals. In case you are an existing patient please mention your UHID no. on this form and submit. However, you need to fill other sections of this form.

UHID No.: (If existing patient of Apollo) _____

(PLEASE WRITE IN BLOCK LETTERS)

Type of Registration : ☐ Normal ☐ Corporate ☐ Event ☐ Camp

Name :

Father Name / Spouse Name :

Marital Status : Single ☐ Married ☐

Sex : Male ☐ Female ☐ Other ☐

Date of Birth : ____ / ____ / ____

Age : years

Contact details:

Address:

City:

State:

Country:

Pin-Code:

Phone:

Email:

Mobile:

I agree to receive SMS alerts in connection with my health care.

Tick ☐ Yes ☐ No

Emergency contact person :

Phone :

Signature of the patient or attendant :

MEDICAL QUESTIONNAIRE

First name		Sur name		DOB	
Home Address		Phone		Email	

As your vaccinator does not always have access to your medical details, please answer the following questions to ensure it is safe for you to have your vaccination.

	Question	Yes	No
1	Are you well today?	☐	☐
2	Have you had been diagnosed with COVID-19 in the last 28 days?	☐	☐
3	Have you had any other vaccinations in the last 7 days?	☐	☐
4	Have you ever had a severe allergic reaction or anaphylaxis?	☐	☐
5	Do you suffer from a bleeding disorder or take any type of anticoagulant (blood thinner)?	☐	☐
6	Do you suffer from any condition, or take any medication or treatment, that may affect your immune system (e.g., cancer, cancer treatments, high dose steroids, etc.)	☐	☐
7	Are you taking any regular medication?	☐	☐
8.	Have you had a COVID-19 vaccination in the last 28 days?	☐	☐
WOMEN ONLY			
9	Could you, or are you pregnant?	☐	☐
10	Are you breastfeeding?	☐	☐

CONSENT TO SHARE INFORMATION

I consent to share my vaccination details with Apollo Hospitals. I understand that my medical details will remain confidential.

Signed:		Date:

First name		Surname	

Informed Consent for Covid-19 Vaccination

In view of the pandemic, the vaccine has been approved on emergency authorization and larger volume of study trials are still required to fully understand the complete effect and long term adverse effects o f the vaccine. However, not getting vaccinated may result in serious infection if exposed to SARS COVID 19.

We have been briefed the following points about vaccination:

Risks: "The most common side effect is pain at the site of injection. Other side effects may be fatigue, low-grade fever, body aches, headache and generalized tiredness, these symptoms typically starts around 12 hours after vaccination and resolves within 48 -72 hours. Very rarely, one may experience severe anaphylactic reaction, including death. Other adverse effects of vaccination include COVID infection, diarrhea, thrombocytopenia, clot formation and bleeding tendency.

Benefits: Vaccines save millions of lives. Vaccines work by training and preparing the body' s natural defenses – the immune system – to recognize and fight the COVID 19 virus. After vaccination, if the body is later exposed to COVID 19 causing virus the body is immediately ready to destroy them, limiting the severity of illness.

Alternatives: Alternative Vaccine such as Covishield, Covaxin, and others COVID appropriate behavior such as wearing masks, maintaining physical distancing and avoiding crowds. Refusal to get vaccinated is another alternative and is a personal choice.

Being vaccinated does not mean that we can throw caution to the wind and put ourselves and others at risk, particularly because we are still unsure on how much the vaccine can protect us not only against disease but also against infection and transmission.

We are fully aware that this is a voluntary service by Apollo Hospitals, as part of its community service initiative to vaccinate more eligible beneficiaries, thereby contributing to contain the spread & severity of COVID 19 infection.

I herby give informed consent for ☐Covishield ☐ Covaxin ☐ Other _____ Vaccination. In the eventuality of any adverse events following vaccination we will not hold Apollo Hospitals or its staff (Doctors & Nurses) responsible. We will also bear the complete cost of treatment if faced with any adverse event that may warrant hospital admission and treatment.

Name: **Signature:** **Date & Time:**