ManipalHospitals
LIFE'S ON
(A UNIT OF MANIPAL HEALTH ENTERPRISES PRIVATE LIMITED)

PATIENT CONSENT FORM

(Please enter details as per your Government approved Identity Card)

Name: _____

Date of Birth (DD/MM/YYYY): __/__/____

Gender : _____

Photo ID Card (AADHAR/PAN/DL/VOTER's ID/PASSPORT):_____
(Please ensure you carry Original Copy)

Photo ID Card Number:_____

Address:_____

_____Pin Code:_____

Mobile Number:_____E-Mail ID:_____

Hospital ID (If registered)

Above mentioned details and Photo ID proof verified: ☐ Yes ☐ No

Name:_____ Signature: _____Employee ID:_____

Are You pregnant / Expecting to be pregnant /
Planning to conceive / Lactating / Having Fever ☐ Yes ☐ No

Are you suffering from any febrile illness/ fever at present: ☐ Yes ☐ No

If Yes, Please provide details: _____

Have you recently suffered from COVID-19 infection: ☐ Yes ☐ No

If yes please specify:_____

Date of report: _____ SRF ID of Positive test:_____

Any history of Allergy to Vaccines: ☐ Yes ☐ No

H/o Comorbidities / Chronic Ailments: _____ ☐ Yes ☐ No

(Diabetes / Hypertension / Cardiac Disease / Neurological / Pulmonary / Renal/Malignancy/ Bleeding / Coagulation disorder)

If Yes, Kindly provide a fitness Certificate for the covid -19 Vaccination from your treating Consultant.

I _____ hereby acknowledge that

- I have understood all information relevant to COVID-19 vaccination which includes details regarding the benefits, Limitations and potential side effects associated with having the COVID-19 vaccination
- I have Gone through and understood the contents of the information booklet
- I have been given the opportunity to ask questions and clarify my concerns
- I hereby give consent to receive the recommended doses of COVID-19 Vaccine
- I agree to abide by all instructions that is required as part of the vaccination process including waiting at the Vaccination site for 30 minutes post vaccination

Signature:

Date: