



COVID-19 VACCINATION QUESTIONNAIRE

Last name: _____

First name: _____

Date of birth: _____

Social security number: _____

Have you had a positive test (PCR or antigen) within the last two months? Yes No

Have you received monoclonal antibody treatment for COVID-19 in the last two months? Yes No

Do you have a fever today? Yes No

Do you have any history of allergies to any substances? Yes No

Have you recently suffered from myocarditis or pericarditis? Yes No

Are you currently taking anticoagulants? Do you have a low platelet count?
Have you suffered from capillary leak syndrome? Yes No

For children under the age of 12, have you suffered from Paediatric Inflammatory Multisystem Syndrome (PIMS) after having had COVID-19? Yes No

For those who have already received a dose of the COVID-19 vaccine, did you suffer from any severe adverse effects after the first injection? Yes No

The identity-related data gathered via this questionnaire will be included in the "SI Vaccin Covid" processing of personal data that is implemented in a joint action by the French Ministry of Health (Ministère de la Santé) and the French National Health Insurance Fund (Caisse nationale d'assurance maladie). This will be done only for the purposes of organising, monitoring and directing the COVID-19 vaccination campaigns. For more information on this processing, the details of the controller, the recipients or groups of recipients, storage periods and the option of lodging an appeal with the French Data Protection Authority (CNIL), please consult the full GDPR notes on the ameli.fr website or scan the QR code. This paper questionnaire can be stored for a maximum duration of three months following the date of your appointment.



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prescriber**

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**MINISTÈRE
DES SOLIDARITÉS
ET DE LA SANTÉ**

*Liberté
Égalité
Fraternité*



TOUS VACCINÉS, TOUS PROTÉGÉS

COVID-19 VACCINATION BOOSTER DOSE QUESTIONNAIRE

Last name: _____

First name: _____

Date of birth: _____

Social security number: _____

How many doses of the COVID-19 vaccine have you already received? _____

When did you receive your last injection? _____

Have you been infected with COVID-19 since you were vaccinated? Yes No

If yes, how long after your injection? _____

Did you suffer from any severe adverse effects after your first vaccination? Yes No

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VACCINATION ANTI-COVID



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