Health statement repeat coronavirus vaccination

This form is only to be filled in for getting a repeat coronavirus vaccination

Please note: It is very important that you complete the questionnaire below. Please bring the completed form with you to the appointment for the repeat coronavirus vaccination.

Please note: *If you are taking medication, please bring a medication list with you to the repeat coronavirus vaccination appointment. You may compile the list yourself, or get it from the pharmacy.*

Coronavirus

		YES	
1	Have you tested positive for coronavirus over the past 3 months?	☐	☐
2	Do you have a fever of 38 degrees Celsius or higher at the moment?	☐	☐
3	Are you experiencing symptoms that resemble coronavirus, such as a runny nose, cough, shortness of breath, tightness of the chest, elevated temperature or fever, loss of smell or taste? If so, then please stay at home and have a coronavirus test administered	☐	☐

If the answer is YES to one or more of the questions 1 - 3, then you cannot get a repeat coronavirus vaccination at this moment.

After a coronavirus vaccination did you experience a severe or immediate allergic reaction?

If so, then you cannot receive a repeat coronavirus vaccination.

Surgery

4	Are you having surgery or will you be put under anesthesia within two days after the repeat coronavirus vaccination?	☐	☐

If the answer to question 4 is YES, then you will get your repeat coronavirus vaccination after your operation.

Pregnancy

5	Are you pregnant?	☐	☐

If YES, then you may receive the repeat coronavirus vaccination.

If you have any questions, please discuss this with your obstetrician, gynecologist or attending physician.

Medical

		YES	NO
6	Have you ever fainted after a vaccination?	☐	☐
7	Have you had a severe allergic reaction before?	☐	☐
	If **YES**: To what? _____		
	Have you been treated for that?	☐	☐
	Do you carry an EpiPen or medication passport with you?	☐	☐
8	Do you have or have you had breast cancer?	☐	☐

If **YES**: ☐ Right ☐ Left

If you have (had) breast cancer, it is important to know on which side you have (had) it, so we may take this into account when inoculating you.

9	Do you use blood thinners/ anti coagulation medication?	☐	☐

If **YES**: Which medication and what dosage did you use in the last seven days?

_____

If you do not know this, please contact your family doctor for a list of the medication that you use.

If you are taking blood thinners/anticoagulants, contact your doctor before you get the repeat coronavirus vaccination. Ask your doctor whether you can receive the repeat coronavirus vaccination and whether any additional measures need to be taken.

10	Do you have an illness that causes your blood not to coagulate?	☐	☐

If **YES**, which one:
- ☐ Hemophilia
- ☐ Von Willebrand disease
- ☐ A platelet deficiency (thrombopathy / thrombocytopenia)
- ☐ Other _____

11	Do you have epilepsy and have you ever had an epileptic seizure in the past when you had fever or after a vaccination?	☐	☐

If the answer is YES to any of the questions 5 to 11, you will need to have a meeting with the doctor at the vaccination location.

Please note: if your medical situation is not included in this health statement, for example, if you have another illness or if you are using other medication, then you may receive the vaccination without concern. Should you have any further questions,you may call the toll-free number 0800-0800. Visit www.bonairegov.com for more information on the coronavirus repeat vaccination.