PREVACCINATION CHECKLIST FOR COVID-19 VACCINATION
for vaccination of minors aged 12-15 (inclusive)
(to be filled out by parent/legal guardian)

Child's Name and Surname: ______________________________

Child's Date of Birth: ______________________________

Parent/Legal Guardian's Phone Number/e-mail: ______________________________

This checklist will help the healthcare professional to assess your child's **current health condition** and circumstances that could have an impact on her/his planned covid-19 vaccination.

Please review the checklist thoroughly and respond **truthfully**. If you answer YES to any question, it does not necessarily mean the child should not be vaccinated. If a question is not clear, please ask the healthcare professional at the vaccination center to explain and help you with relevant answers.

	YES	NO
Does your child feel sick now? Does s/he have any symptoms?	☐	☐
Has your child recovered from COVID-19?	☐	☐
Has your child received a dose of COVID-19 vaccine?	☐	☐
Has your child ever had a severe allergic reaction to another vaccine?	☐	☐
Does your child have any chronic health condition? Does s/he take any permanent medication?	☐	☐
Does your child have a severely weakened immune systém?	☐	☐
Has your child received any vaccine in past two weeks? Do you plan any other vaccination in the near future?	☐	☐

Note: Inform your child's attending pediatrician about your child's COVID-19 vaccination.

By attaching my signature to this checklist below I confirm that **I have not witheld any information** about my child's health condition; and **I understand the information** about COVID-19 vaccination provided, including possible side effects.

______________________ date

______________________ date

______________________ Parent/legal guardian's signature

______________________ Stamp and signature of healthcare professional