MINISTÈRE
DES SOLIDARITÉS
ET DE LA SANTÉ

Liberté
Égalité
Fraternité

VACCINATION AGAINST THE COVID-19 SURVEY

Family Name: ……...

First Name: ……..

Date Of Birth: ……...

Social Security Number : ……

Have you been tested positive (PCR or antigen test) in the past three months?	☐ **Yes** ☐ No
Do you have fever today?	☐ **Yes** ☐ No
Have you received any vaccine in the past two weeks? If yes, which type: …….	☐ **Yes** ☐ No
Do you have any history of allergy or hypersensitivity to certain substances or to other vaccines?	☐ **Yes** ☐ No
Do you have any bleeding disorders? (especially low platelets or anticoagulant therapy)	☐ **Yes** ☐ No
Are you pregnant ?	☐ **Yes** ☐ No
Are you breastfeeding ?	☐ **Yes** ☐ No

Reserved for the doctor

Date : ……./……../…….

Signature of the doctor :

Version du 08 janvier 2021