Prevaccination screening questionaire for COVID-19 vaccination

- I have received sufficient amount of information regarding the Coronavirus disease-19 (hereon refer to Corona19) vaccination and possible adverse reactions, and I agree to receive vaccination based on my medical examination results. ☐ agree ☐ I don't agree
- If you agree to receive the COVID-19 vaccination, please read the following questions to ensure a safe vaccination procedure, and fill out the form under "Self-(legal representative or guardian) confirmation checkbox" column.

Name		Resident Registration number (Alien Registration number)		Sex	
Phone #	(home)		(Mobile)		

Consent to process personal information for vaccination purposes	Self- (legal representative or guardian) Confirmation ☐

Personal and sensitive information is collected according to Article 33.4 of the Infectious Disease Control and Prevention Act and Article 32.3 of the Enforcement Decree of the Infectious Disease Control and Prevention Act. Additional items collected are as follows:

- Purpose to notify the patient of information related to the second dose of vaccine, completion status, possible adverse reactions, vaccination, etc.
- Items collected and used: Personal information (confidential information, including Resident Registration Number), contact information (home/mobile phone #)
- Record retention period: 5 years

1. I agree to make preliminary inquiries to confirm the COVID-19 vaccination records from the "COVID-19 Vaccination Management System" before procedure. *It may lead to unnecessary additional or duplicated injection if you do not agree to the preliminary confirmation of vaccination records.	☐ Yes ☐ No
2. I agree to receive notifications of information regarding COVID-19 vaccination, including the second dose and completion status, via text messages. *You will not receive information on items for which you did not provide consent if you do not agree.	☐ Yes ☐ No
3. I agree to receive notifications of information regarding abnormal reactions caused by the COVID-19 vaccination via text messages. *You will not receive information on items for which you did not provide consent if you do not agree.	☐ Yes ☐ No

Patient Confirmation Items	Self- (legal representative or guardian) Confirmation ☐
① (For female) Are you pregnant currently?	☐ Yes ☐ No
② Do you feel particularly sick today? If so, please indicate symptoms.	☐ Yes ☐ No
③ Have you received a test of COVID-19? If so, please indicate the test date (Year Month Day)	☐ Yes ☐ No
④ Have you received any vaccination (other than COVID-19) in the past 14 days?	☐ Yes ☐ No
⑤ Have you received COVID-19 vaccination? If you answered **"No", skip to 6**. If you answered "Yes", please write vaccination date (vaccination date: Year Month Day)	☐ Yes ☐ No
⑤ **- 1** Have you received treatment for severe allergic reactions after receiving the COVID-19 vaccination (Anaphylaxis: shock, difficulty in breathing, loss of consciousness, edema on lips/inside of mouth, etc.)? (Name of vaccine with such reactions:)	☐ Yes ☐ No
⑥ Have you received treatment for severe allergic reactions (Anaphylaxis: shock, difficulty in breathing, loss of consciousness, edema on lips/inside of mouth, etc.)? Please indicate the causes for such reactions if known.	☐ Yes ☐ No
⑦ Do you have a bleeding disorder or are you taking a blood thinner? If so, please list the type of disorder or the name of blood thinner. ( )	

Name (Oneself/Legal representative/guardian): (Signature) Relationship to the patient:

Examination Results (to be completed by a physician)		confirmation
Temperature:	I explainted the possible adverse reactions after the vaccination (Confimation)	☐
I explained that the patient should stay at the vaccination facility for 15-30 minutes after receiving the vaccination to observe possible adverse reactions.		☐

Examination results	Eligible for vaccination
	rescheduling vaccination (reason:)
	contraindication (reason:)

I hereby confirm that I have made the above diagnosis. Name (Signature)

Vaccination (for vaccinators)		
Manufacturer	Vaccine Product number	Vaccination location
		☐ Left upper arm ☐ Right upper arm
		Vaccinator name (signature)