시각장애인을 위한 QR코

Form

Vaccination Prevaccination Screening Questionnaire for Covid-19 Vaccination

- I have received sufficient information regarding the COVID-19 vaccination and possible adverse reactions, and agree to receive vaccination based on my medical exam results. ☐ I agree ☐ I do not agree
- If you agree to receive the COVID-19 vaccination, please read the following questions to ensure a safe vaccination process, and fill-out the form below(or seek the help of a legal representative/guardian)

Full Name		Resident Registration Number (Alien Registration Number)	- (☐Male ☐Female)
Contact Number	(Home)	(Mobile Phone)	

Consent to Process Personal Informaion for Vaccination Purposes	SelfConfirmation (by self, legal representative /guardian ☑
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 of collecting and using personal information: To notify or provide information related to the second injection, completion status, possible adverse reactions after vaccination etc. ▪ Items of Personal Information Collected and Use: Personal Information(including sensitive information and resident registration number), phone number(home/mobile phone) ▪ Period of retention and use of information : 5 years	
1. I agree to check my vacciantion history with<COVID-19 Vaccination Management System> before being vaccinated against COVID-19. * If you do not agree to the prior confirmation of vaccination details, unnecessary additional or cross-vaccination may occur.	☐ yes ☐ no
2. I agree to receive information regarding the next vaccination and completion of the COVID-19 vaccination, and text messages related to the occurrence of adverse reactions after the COVID-19 vaccination. *If you do not agree to receive text, you will not receive information about items you do not agree to receive. ※ However, in order to protect the life and health of the vaccinated person, information may be provided regardless of consent in the case of important information related to adverse reactions.	☐ yes ☐ no

Patient Confirmation Items	Confirmation (by self, legal representative /guardian) ☑
① (Female) Are you pregnant?	☐ yes ☐ no
② Do you feel particularly sick today? If so, please indicate the symptoms.( )	☐ yes ☐ no
③ Have you ever been diagnosed with covid 19? If yes, please write the date of diagnosis.(Year Month Day)	☐ yes ☐ no
④ Have you received any vaccine (other than the COVID-19 vaccine) within the last 14 days?	☐ yes ☐ no
⑤ Have you ever been vaccinated against COVID-19? ☞ In case of "NO", go to question ⑥. If yes, please indicate the date of vaccination(Date: Year Month)	☐ yes ☐ no
⑤-1 Have you ever received treatment for a severe allergic reaction(anaphylaxis : shock, difficulty in breathing, loss of consciousness, swelling of lips/mouth, etc.)after being vaccinated against COVID-19? (Vaccines with severe allergic reactions:)	☐ yes ☐ no
⑤-2 After receiving the COVID-19 vaccine, have you had any serious adverse reactions such as thrombocytopenic thrombosis, capillary leakage syndrome, myocarditis/pericarditis, etc.? (Type of serious adverse reactions: , Type of vaccine with adverse reactions :)	☐ yes ☐ no
⑥ Have you previously been treated for severe allergic reactions(anaphylaxis : shock, shortness of breath, loss of consiousness, swelling in the lips/mouth, etc.)? If so, please indicate what caused the severe allergic reaction.( )	☐ yes ☐ no
⑦ Are you suffering from homostatic(blood clotting) disorder or receiving anticoagulant treatment? If yes, please indicate the name of the disease or type of medicine. ( )	☐ yes ☐ no
Patient's(legal representative, guardian) Fullname : (Signature) Relationship with the patient : Year Month Day	

Examination Results (to be fill-out by a physician)		Confirmation ☑
Temperature : ℃	Adverse reactions after vaccination were explained.	☐
Explained that 'to observe adverse reactions, you must stay at the vaccination facility for 15 to 30 minutes after vaccination'		☐

Preliminary Results	
	☐ Eligible for Vaccination
	☐ Vaccination Postponed(Reason:)
	☐ Prohibit from vaccination(Reason:)

I hereby confirm that the above consultation and examinations have been carried out. Physician's Name (Signature)

Vaccination Administrative Records		
Manufacturing Company	Vaccine Serial Number	Part of the Body(Vaccination)
		☐ Left upper arm ☐ Right Upper Arm
Vaccinator: (Signature)		