VIC Medical Service
Your Health Link at the Vienna International Centre

Tick Vaccine Registration/Consent Form

	Please answer these questions	Yes	No	Not Sure
1	Do you have fever now?			
2	Do you have an acute infection now?			
3	Have you ever had a severe reaction to any vaccine in the past?			
4	Do you have or had a neurological disorder?			
5	Are you pregnant or trying to get pregnant?			
6	Is your immune system affected due to illness or medications?			
7	Are you under treatment for any disease or condition?			
8	Do you have a recent tick bite?			

Please write in bold letters- needed for computer entries.

For Staff only

Family name: _____ *First name*: _____

Date of Birth: (dd-mm-yyyy) _____ *Gender*: _____ *Nationality*: _____

Organization: _____ *Extension/telephone*: _____

For Dependants* only

Family name: _____ *First name*: _____

Date of Birth: (dd-mm-yyyy) _____ *Gender*: _____ *Nationality*: _____

Name of Staff member: _____

Organization: _____ *Extension/telephone*: _____

I wish to register for: *(mark as appropriate)*

First dose: ___ Second dose: ___ Third dose: ___ Booster: ___

I have provided correct and complete information. I consent to be vaccinated against tick.

_____ _____

(Signature) *(Date)*