

VACCINATION CONSENT FORM

The undersigned ; Surname _____ Name _____
 born in _____ on _____ Tax Code C.F.* _____
 Residing in _____ Street/Square(Piazza) _____ N° _____
 phone number _____ email _____
 Identified with document _____ N° _____
 Expired on ____/____/____ Issued by _____

And

The undersigned ; Surname _____ Name _____
 born in _____ on _____ Tax Code C.F.* _____
 Residing in _____ Street/Square(Piazza) _____ N° _____
 phone number _____ email _____
 Identified with document _____ N° _____
 Expired on ____/____/____ Issued by _____

IN THE RESPECTIVE CAPACITIES OF

In case of a minor:

Parent(s) exercising parental authority over the child: _____
 born in _____ on ____/____/____

Or, in the case of an incapacitated individual:

Legal representative (guardian or other) of: _____
 born in _____ on ____/____/____

*(not mandatory)

I DECLARE / WE DECLARE:

1. To have acquired the consent of the other parent (if absent) who, unable to attend today, has been personally informed by the undersigned of the need to carry out the vaccination.
2. that I have correctly reported the information on the personal data and health conditions of your child or the person you legally represent.
3. **to have received information on the disease(s) to be prevented, on the characteristics of the vaccine(s) used and on the benefits and potential risks of the vaccination(s) and on the number of administrations foreseen by the current vaccination calendar;**
4. **to have had the opportunity to ask questions and to have understood the answers to requests for clarification regarding the vaccination(s);**
5. that I have read and understood the information pursuant to articles 13 and 14 of regulation 2016/649/EU "General regulation on the protection of personal data" of the ASL ROMA 2;
6. that I understand that all data will be processed in compliance with the protection rules established by the aforementioned Regulation.
7. that I understand that the ASL Roma 2, whose identification details are reported in the information, is the data controller and that it is necessary to provide and allow the processing of data in order to be vaccinated;
8. that I understand that ASL ROMA 2 has appointed a Data Protection Officer who can be reached at the email address: dpo@aslroma2.it
9. to have understood that in this ASL there is an active computerized vaccination registry in which data relating to the administration of vaccines are stored (Agreement pursuant to art.8, paragraph 6 of Law 5 June 2003 n.131, between the Government, the Regions and Autonomous Provinces of Trento and Bolzano on the document containing the "National Vaccine Prevention Plan (PNPV) 2017-2019") and the consents expressed through this form;
10. that I understand that all the rights referred to in articles 15 et seq. can be exercised against ASL Roma 2. of the Regulations expressly including **the right to revoke/modify the consents expressed in this form at any time;**
11. that I understand that the National Vaccine Plan (see point 9) invites ASL to carry out, in order to promote mandatory and recommended vaccinations, so-called "active calls" or personal invitations to undergo vaccinations;
12. that I understand that the processing of data relating to vaccinations administered is also carried out for reasons of public interest and that said data will never be disclosed for any other purpose;
13. to have understood that interested parties who believe that the processing of personal data relating to them carried out by ASL Roma 2 occurs in violation of the provisions of the Regulation, have the right to file a complaint with the guarantor for the protection of personal data, as provided from art.77 of the Regulation itself, or to take action in the appropriate judicial offices (art.79 of the Regulation).

ALL THE ABOVE BEING UNDERSTOOD, THE UNDERSIGNED

☐ **AGREE**

☐ **DOES NOT AGREE**

To the processing of their own personal data and that of the minor, incapacitated/disqualified person they legally represent for the management of the vaccination process;

Expresses its consent to carrying out the basic cycle and subsequent boosters for all mandatory and optional vaccinations - according to the existing formulations on the market - provided for by the National Vaccine Prevention Plan 2017-2019 and Legislative Decree 7 June 2017 n.73, as amended by the Conversion Law of 31 July 2017 n.119 listed below:

YES NO

- | | | | |
|--------------------------|--------------------------|---|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Hexavalent | (anti-diphtheria-tetanus-pertussis-polio-hemophilusB-hepatitisB) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pentavalent | (anti-Diphtheria-Tetanus-pertussis-polio-haemophilusB) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pediatric tetravalent | (anti-Diphtheria-Tetanus-pertussis-polio) |
| <input type="checkbox"/> | <input type="checkbox"/> | Adult tetravalent | (anti-diphtheria-tetanus-pertussis-polio) |
| <input type="checkbox"/> | <input type="checkbox"/> | Trivalent | (anti-diphtheria-tetanus-pertussis-pertussis) |
| <input type="checkbox"/> | <input type="checkbox"/> | MPRV | (anti-Morbillus-Mumps-Rubella-Varicella) |
| <input type="checkbox"/> | <input type="checkbox"/> | MPR | (anti-Morbillus-Potitis-Rubella) |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-HemophilusB | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Hepatitis A | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Hepatitis A+B | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-HepatitisB pediatric | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-HepatitisB adult | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-HepatitisB for hemodialysis | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Herpes Zoster recombinant | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti- Herpes Zoster attenuated | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Meningococcal ACYW135 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Meningococcal B | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Papillomavirus HPV9 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Pneumococcus15 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Pneumococcal 20 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Pneumococcal23 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Polio IPV | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Rotavirus | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Varicella | |
| <input type="checkbox"/> | <input type="checkbox"/> | Others _____ | |

Date

Signature

Facility

Signature of the physician receiving the consent