RABIES INFORMATION FORM

Rabies is a preventable fatal disease can be transmitted from animals to humans. You may have faced the risk of Rabies by biting or scratching of a domestic or wild animal and contacting of the rabid animal's saliva to scratches or cracks on your skin, your eyes, your nose or your mouth.

Therefore, according to your doctor's assessment, medical interventions performed to you and specified to the Vaccine Follow-up Card. An appropriate vaccination schedule is planned for you.

It is of vital importance to have vaccinated on the days indicated in the vaccination card with the condition of the applicant together with the vaccination card at this healthcare institute or other healthcare institutes that implements the rabies vaccine.

I have read the information written above. I have been informed about possible rabies exposure and rabies disease that may occur after. I have been informed about the importance of vaccinating against rabies on the remaining dates specified at Vaccine Follow-up Card and took delivery of the vaccine card.

In case of rejecting planned medical interventions to be performed to me and/or not vaccinating for the rabies or not completing the rabies vaccination schedule after possible rabies exposure, all the responsibility belongs to me.

Patient's Name-Surname: ….....
Passport Number: .....
Address: .....
Phone: .....

Patient's Legal Representative *, if any:
Name-Surname: …….….....
Passport Number: .....
Address: .....
Phone: .....

Patient's or Patient's Legal Representative's Signature:

Of the Physician who has informed the patient or patient's legal representative;
Name-Surname:…….
Signature:……..

*Legal Representative: Guardian for those under guardianship, parents for minors, their legal heirs in situations where there are no first degree kinship. Indicate the degree of kinship next to patient's name.