MOH COVID-19 VACCINATION FORM - FORM 1

TO BE COMPLETED BY PATIENT (please approach our staff if you need help)

PART A: PERSONAL PARTICULARS

Queue *Registration*

NAME (BLOCK LETTERS):	**NRIC No./Foreign Identification No.(FIN):**

Gender:	**Date of Birth (dd/mm/yyyy):**	**Age:**	**Ethnic Group:**		**Residential Status:**	
☐ Male			☐Chinese	☐ Indian	☐ Citizen	☐ Long term
☐ Female			☐ Malay	☐ Others	☐ Permanent Resident	☐ Other

Address*:	**Handphone Number:**
Postal Code:	**Email Address*:**

PART B: MEDICAL INFORMATION

Waiting Area

PART B1: FEVER & VACCINATION	**NO**	**YES**
Have you had a fever or any vaccination recently?		
• Fever (Temperature ≥ 37.5°C) in the past 24 hours?	☐	☐
• Any vaccination in the past 14 days?	☐	☐

PART B2: IMMUNOCOMPROMISE	**NO**	**YES**
Do you have any medical conditions causing severe immunocompromise? For example:	☐	☐
• Recent transplant in the past 3 months		
• Active cancer not in remission		
• On cancer treatment (immunotherapy / chemotherapy / radiotherapy)		
• HIV with CD4 count < 200		

PART B3: ALLERGIES	**NO**	**YES**
Have you ever had any severe allergies to vaccines, medications, bee sting, food?		
• Anaphylaxis or severe allergic reaction (difficulty breathing, face / throat /eye / lip swelling etc)	☐	☐
• Any other food or drug allergies? List: _____	☐	☐

PART B4: OTHER PRECAUTIONS	**NO**	**YES**
Are you currently taking these medications or have these medical conditions?		
• Blood-thinning medications (anti-coagulation)	☐	☐
• Bleeding disorder or low platelets	☐	☐

PART B5: PREGNANCY & RELATED QUESTIONS (FOR FEMALES ONLY)	**NO**	**YES**
• Are you pregnant or suspect that you are pregnant (late menstrual period)?	☐	☐
• Are you currently breastfeeding?	☐	☐
• Date of 1st day of last menstrual period (if younger than 50 years of age): _____		

PART C: PATIENT DECLARATION AND CONSENT

I declare that the information I have given is true and complete to the best of my knowledge

I have been informed of the risks, benefits and side effects of COVID-19 vaccination, and I wish to receive COVID-19 vaccination

☐ I **AGREE** to receive COVID-19 vaccination; OR ☐ I **DO NOT** wish to receive COVID-19 vaccine**

_____	_____	_____	_____
Name of patient / parent / guardian	NRIC No. / FIN	Signature	Date (dd/mm/yyyy)

* Fields not required if names are submitted via nominal roll, appointment booking system and healthcare workers under the self-vaccination exercise.

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MOH COVID-19 VACCINATION FORM (ASSESSMENT CLINIC) – FORM 2
TO BE COMPLETED BY DOCTOR OR NURSE

PART D: CLINICAL SAFETY REVIEW OF PATIENTS		
PART D1: NOT ELIGIBLE FOR COVID-19 VACCINATION **IF YES → DO NOT VACCINATE** Is the patient:	**NO**	**YES**
• Pregnant	☐	☐
• Child under age 16 years	☐	☐
• Severely immunocompromised - Recent transplant in the past 3 months - Active cancer - Cancer treatment (immunotherapy / chemotherapy / radiotherapy) - HIV with CD4 count < 200	☐	☐
PART D2: CONTRAINDICATIONS TO COVID-19 VACCINE **IF YES → DO NOT VACCINATE**	**NO**	**YES**
• Anaphylaxis to first dose of COVID-19 vaccine	☐	☐
• History of anaphylaxis or severe allergic reactions	☐	☐
PART D3: PRECAUTIONS → POSTPONE VACCINATION **IF YES → DO NOT VACCINATE**	**NO**	**YES**
• Fever (≥ 37.5°C) in past 24 hr → Re-schedule vaccination when fever has resolved	☐	☐
• Vaccination in past 14 days → Re-schedule vaccination after 14 days	☐	☐
PART D4: PRECAUTIONS → CAN VACCINATE **IF YES → ADVISE HOLD FIRM PRESSURE AT INJECTION SITE FOR 5 MINUTES**	**NO**	**YES**
• On anti-coagulation, has bleeding disorder or low platelets	☐	☐

CLINICAL ASSESSMENT: ☐ Risks, benefits, adverse effects discussed ☐ Patient form & consent checked **VACCINATE?** ☐ YES → PROCEED TO VACCINATION ☐ NO ☐ Not eligible OR has contraindications → NO VACCINATION ☐ Fever → RESCHEDULE vaccination when fever has resolved ☐ Vaccination → RESCHEDULE vaccination to after 14 days	Form Completed by _____ Name (stamp) / Signature / Date

PART E: VACCINATION RECORD			
COVID-19 vaccine given: ☐ #1 Date: ☐ #2 Date:	Injection site: ☐ Left deltoid ☐ Right deltoid ☐ Other_____	Vaccine Brand: ☐ Pfizer-BioNTech ☐ Moderna ☐ Sinovac ☐ Other _____	Batch number: Bottle number (if applicable):
Place of Vaccination:		Vaccinated by: _____ Name (stamp) / Signature / Date	

PART F: OBSERVATION & DISCHARGE	
☐ Vaccine card & vaccine information sheet (VIS) given ☐ Observe patient for 30 min after vaccination (for syncope, anaphylaxis etc)	Time of vaccination:
Remarks by doctor (If treatment required):	Assessed by: _____ Name (stamp) / Signature / Date