

MOH PFIZER-BIONTECH COVID-19 VACCINATION FORM - FORM 1
TO BE COMPLETED BY PATIENT (please approach our staff if you need help)

PART A: PERSONAL PARTICULARS										<i>Queue Registration</i>	
NAME (BLOCK LETTERS):						NRIC No./Foreign Identification No.(FIN):					
<div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female </div> <div style="width: 20%;"> Date of Birth (dd/mm/yyyy): <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"></div> </div> <div style="width: 20%;"> Age: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"></div> </div> <div style="width: 20%;"> Ethnic Group: <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Malay <input type="checkbox"/> Others </div> <div style="width: 40%;"> Residential Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Long term <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other </div> </div>											
Address*:						Handphone Number:					
Postal Code:						Email Address*:					
PART B: MEDICAL INFORMATION										<i>Waiting Area</i>	
PART B1: FEVER & VACCINATION										NO	YES
Have you had a fever or any vaccination recently?											
<ul style="list-style-type: none"> Fever (Temperature $\geq 37.5^{\circ}\text{C}$) in the past 24 hours? Any vaccination in the past 14 days? 										<input type="checkbox"/>	<input type="checkbox"/>
PART B2: IMMUNOCOMPROMISE										NO	YES
Do you have any medical conditions causing severe immunocompromise? For example:										<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> Recent transplant in the past 3 months Aggressive Immunotherapy for non-cancer conditions (eg. rituximab etc) HIV with CD4 count < 200 											
PART B3: ALLERGIES TO VACCINES										NO	YES
Have you ever had any allergic reactions to vaccines:											
<ul style="list-style-type: none"> Anaphylaxis: severe reaction with two or more of the following: (a) hives or face/eyelid/lip/throat swelling, (b) difficulty breathing, (c) dizziness Have you had rash OR hives OR face/eyelid/lip swelling to vaccines? 										<input type="checkbox"/>	<input type="checkbox"/>
PART B4: SPECIAL SITUATIONS (CAN STILL VACCINATE)										NO	YES
Have you ever had anaphylaxis to medications, insect stings, food or unknown triggers ?										<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking these medications or have these medical conditions?											
<ul style="list-style-type: none"> Blood-thinning medications (e.g. warfarin, apixaban, rivaroxaban etc) Bleeding disorder or low platelets On cancer treatment (immunotherapy / chemotherapy / radiotherapy in the past 3 months OR planned in the next 2 months) *Must consult treating oncologist (For Females only) Are you pregnant or suspect that you are pregnant (late menstrual period)? *Must consult obstetrician to discuss risks and benefits of vaccination 										<input type="checkbox"/>	<input type="checkbox"/>
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											
<input type="checkbox"/> I AGREE to receive COVID-19 vaccination; OR <input type="checkbox"/> 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.

** If patient **does not** wish to receive COVID-19 vaccine, there is no need to complete **FORM 2**.

MOH PFIZER BIONTECH 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		NO	YES
• Child under age 12 years		<input type="checkbox"/>	<input type="checkbox"/>
• Severely immunocompromised		<input type="checkbox"/>	<input type="checkbox"/>
- Recent transplant in the past 3 months			
- Aggressive Immunotherapy for non-cancer conditions (e.g. rituximab etc)			
- HIV with CD4 count < 200 cells/mm ³			
PART D2: CONTRAINDICATIONS TO COVID-19 VACCINE		NO	YES
IF YES → DO NOT VACCINATE			
• Allergic reaction or anaphylaxis to previous dose of COVID-19 vaccine, or any of its components		<input type="checkbox"/>	<input type="checkbox"/>
PART D3: PRECAUTIONS → POSTPONE VACCINATION		NO	YES
IF YES → DO NOT VACCINATE			
• Fever (≥ 37.5°C) in past 24 hr → Re-schedule vaccination when fever has resolved		<input type="checkbox"/>	<input type="checkbox"/>
• Vaccination in past 14 days → Re-schedule vaccination after 14 days		<input type="checkbox"/>	<input type="checkbox"/>
• Rash OR urticaria OR face/eyelid/lip swelling OR anaphylaxis to VACCINES → Refer to allergist*		<input type="checkbox"/>	<input type="checkbox"/>
PART D4: SPECIAL SITUATIONS → CAN VACCINATE		NO	YES
IF YES to being on anti-coagulation, has bleeding disorder or low platelets →			
• ADVISE HOLD FIRM PRESSURE AT INJECTION SITE FOR 5 MINUTES		<input type="checkbox"/>	<input type="checkbox"/>
IF YES to being/possibly pregnant →			
• CHECKED THAT RISKS & BENEFITS DISCUSSED WITH OBSTETRICIAN?		<input type="checkbox"/>	<input type="checkbox"/>
IF YES to being on cancer treatment (immunotherapy / chemotherapy / radiotherapy) less than 3 months ago OR planned in the next 2 months →			
• CHECKED THAT SUITABILITY ASSESSED BY ONCOLOGIST?		<input type="checkbox"/>	<input type="checkbox"/>
IF YES to history of anaphylaxis →			
• ENSURE POST-VACCINATION OBSERVATION PERIOD OF 30 MINUTES		<input type="checkbox"/>	<input type="checkbox"/>
CLINICAL ASSESSMENT: <input type="checkbox"/> Risks, benefits, adverse effects discussed <input type="checkbox"/> Patient form & consent checked VACCINATE? <input type="checkbox"/> YES → PROCEED TO VACCINATION <input type="checkbox"/> NO <input type="checkbox"/> Not eligible OR has contraindications → NO VACCINATION <input type="checkbox"/> Fever → RESCHEDULE vaccination when fever has resolved <input type="checkbox"/> Recent other vaccine → RESCHEDULE to 14 days after other vaccine <input type="checkbox"/> Cutaneous reaction to other VACCINES → Refer to allergist*		Form Completed by _____ Name (stamp) / Signature / Date	
PART E: VACCINATION RECORD			
COVID-19 vaccine given:	Injection site:	Vaccine Brand:	Batch number:
<input type="checkbox"/> #1 Date:	<input type="checkbox"/> Left deltoid	<input type="checkbox"/> Pfizer-BioNTech	
<input type="checkbox"/> #2 Date:	<input type="checkbox"/> Right deltoid	<input type="checkbox"/> Moderna	
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Sinovac	Bottle number (if applicable):
		<input type="checkbox"/> Other _____	
Place of Vaccination:		Vaccinated by:	
		_____ Name (stamp) / Signature / Date	
PART F: OBSERVATION & DISCHARGE			
<input type="checkbox"/> Vaccine card & vaccine information sheet (VIS) given <input type="checkbox"/> Observe patient for 30 min after vaccination (for syncope, anaphylaxis etc) <input type="checkbox"/> If allergic symptoms develop in first 30 min, observe until stable or refer to ED			Time of vaccination:

Remarks by doctor (If treatment required):	Assessed by: <hr/> Name (stamp) / Signature / Date
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* Please refer to the [Allergist Referral Form for COVID-19 vaccination] if the individual is eligible for further evaluation by an allergist.