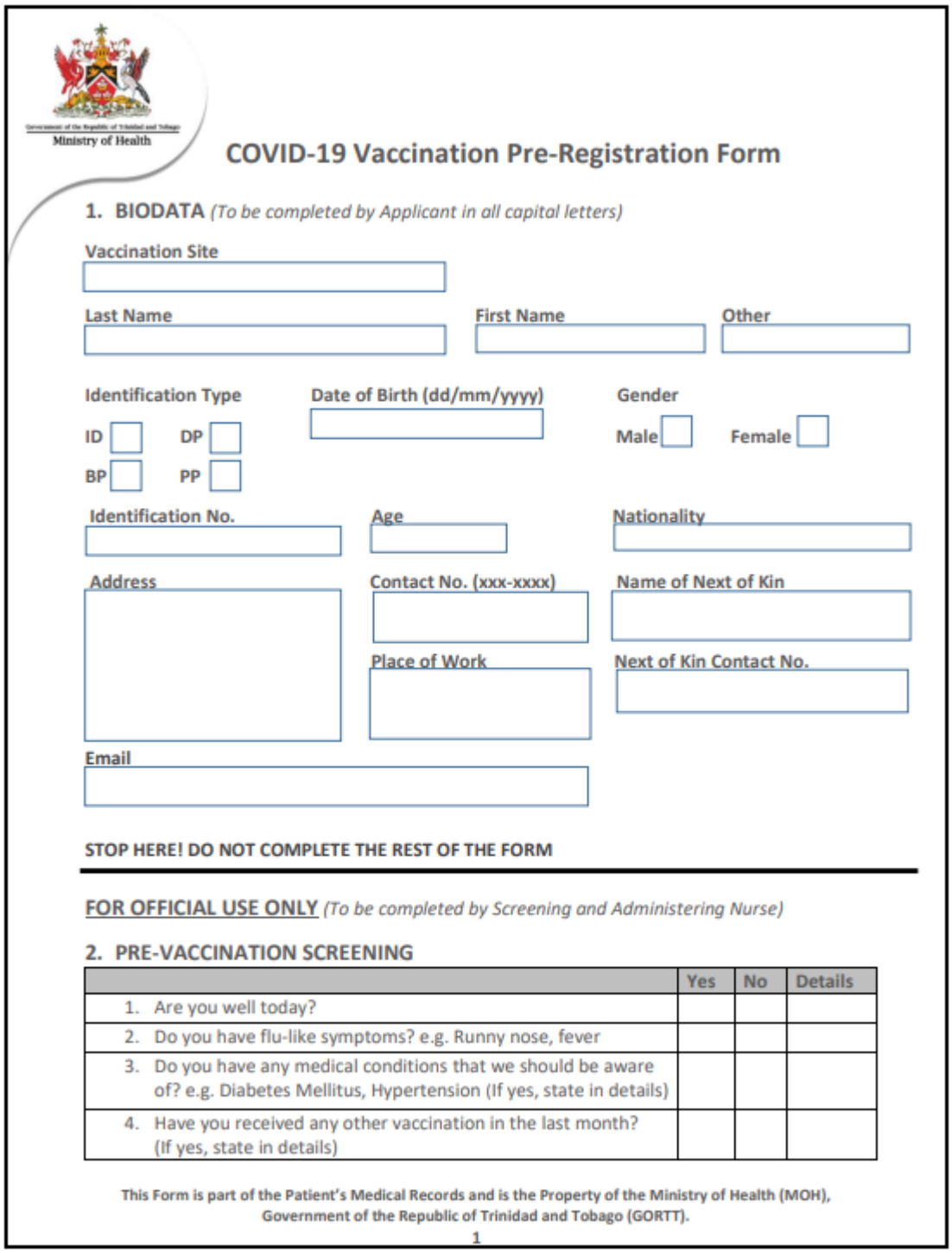
INTR3001 / WEBP3001

ASSIGNMENT 2

HTML5 Forms, CSS

The image below is an official Ministry of Health form for all nationals of Trinidad and Tobago to register for the COVID19 vaccine.



Ministry of Health

COVID-19 Vaccination Pre-Registration Form

1. BIODATA *(To be completed by Applicant in all capital letters)*

Vaccination Site

Last Name | First Name | Other

Identification Type: ID ☐ DP ☐ BP ☐ PP ☐

Date of Birth (dd/mm/yyyy)

Gender: Male ☐ Female ☐

Identification No. | Age | Nationality

Address | Contact No. (xxx-xxxx) | Name of Next of Kin

Place of Work | Next of Kin Contact No.

Email

STOP HERE! DO NOT COMPLETE THE REST OF THE FORM

FOR OFFICIAL USE ONLY *(To be completed by Screening and Administering Nurse)*

2. PRE-VACCINATION SCREENING

	Yes	No	Details
1. Are you well today?			
2. Do you have flu-like symptoms? e.g. Runny nose, fever			
3. Do you have any medical conditions that we should be aware of? e.g. Diabetes Mellitus, Hypertension (If yes, state in details)			
4. Have you received any other vaccination in the last month? (If yes, state in details)			

This Form is part of the Patient's Medical Records and is the Property of the Ministry of Health (MOH), Government of the Republic of Trinidad and Tobago (GORTT).

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CONFIDENTIAL

	Yes	No	Details
5. Do you have allergies? e.g. Seafood, eggs, antibiotics (If yes, state in details)			
6. Have you ever had a confirmed allergic reaction to the first dose of the COVID-19 vaccine?			
7. Are you currently pregnant?			
8. Are you currently breastfeeding?			
9. Have you tested positive for coronavirus infection within the last 3 months?			
10. Do you have a bleeding disorder, or are you currently taking or have recently stopped taking Warfarin?			
11. Do you have any questions about your vaccination today?			
12. Do you consent to receiving the COVID-19 vaccine?			
13. Is this your second dose of COVID-19 Vaccine?			
14. Did you contract the COVID-19 Virus after your first shot? If yes what date?			

3. VACCINATION INFORMATION

Date of Vaccination (dd/mm/yyyy)

Name of Vaccine | **Expiry Date** | **Batch No.**

Blood Pressure | **Blood Glucose Level**

Observation

Time In:

Time Out:

Adverse Reaction — **Yes** ☐ **No** ☐

Description of Event

Immunization Card Issued

Next Appointment Date

Name of Vaccinator (CAPS)

Signature of Vaccinator

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Source https://health.gov.tt/download-the-covid-19-vaccine-pre-registration-forms

Develop a web based data entry form providing guidance and footnotes