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 *Queue* *Registration*

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

Gender:	Date of Birth (dd/mm/yyyy):	Age:	Ethnic Group:		Residential Status:	
☐ Male ☐ Female			☐ Chinese ☐ Malay	☐ Indian ☐ Others	☐ Citizen ☐ Permanent Resident	☐ Long term ☐ 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		
• Aggressive Immunotherapy for non-cancer conditions (eg. rituximab etc)		
• HIV with CD4 count < 200		

PART B3: ALLERGIES	**NO**	**YES**
Have you ever had any severe allergic reactions to *vaccines, medications, insect stings, food etc*:		
• Anaphylaxis: severe reaction with two or more of the following: (a) hives or face/eyelid/lip/throat swelling, (b) difficulty breathing, (c) dizziness	☐	☐
• Ever been prescribed with an Epi-Pen? (self-injected epinephrine for severe allergy)	☐	☐
• Have you had rash OR hives OR face/eyelid/lip swelling to vaccines?	☐	☐

PART B4: SPECIAL SITUATIONS (CAN STILL VACCINATE)	**NO**	**YES**
Are you currently taking these medications or have these medical conditions?		
• 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	☐	☐

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.

** 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	☐	☐
• Severely immunocompromised - 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 **IF YES → DO NOT VACCINATE**	**NO**	**YES**
• Allergic reaction to previous dose of COVID-19 vaccine, or any of its components	☐	☐
• History of anaphylaxis or prescribed an Epi-Pen	☐	☐
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	☐	☐
• Rash OR urticaria OR face/eyelid/lip swelling to VACCINES → Refer to allergist*	☐	☐
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**	☐	☐
IF YES to being/possibly pregnant →		
• **CHECKED THAT RISKS & BENEFITS DISCUSSED WITH OBSTETRICIAN?**	☐	☐
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?**	☐	☐

CLINICAL ASSESSMENT:	Form Completed by
☐ 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 ☐ Recent other vaccine → RESCHEDULE to 14 days after other vaccine ☐ Cutaneous reaction to other VACCINES → Refer to allergist*	_____ Name (stamp) / Signature / Date

PART E: VACCINATION RECORD

COVID-19 vaccine given:	Injection site:	Vaccine Brand:	Batch number:
☐ #1 Date: ☐ #2 Date:	☐ Left deltoid ☐ Right deltoid ☐ Other_____	☐ Pfizer-BioNTech ☐ Moderna ☐ Sinovac ☐ Other _____	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) ☐ 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: _____ Name (stamp) / Signature / Date

* Please refer to the [Allergist Referral Form for COVID-19 vaccination] if the individual is eligible for further evaluation by an allergist.