MOH MODERNA / SPIKEVAX 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 ☐ Indian ☐ Malay ☐ Others	☐ Citizen ☐ Long term ☐ Permanent Resident ☐ Other

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

PART B: MEDICAL INFORMATION *Waiting Area*

PART B1: FEVER	**NO**	**YES**
Have you had a fever (temperature ≥ 37.5°C) in the past 24 hours?	☐	☐
PART B2: ADVERSE EVENTS TO VACCINES	**NO**	**YES**
Have you ever had any allergic reactions to a previous dose of an mRNA COVID-19 vaccine (Pfizer-BioNTech/Comirnaty or Moderna/Spikevax)		
• 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?	☐	☐
Have you had any allergic reactions to other COVID-19 vaccines?	☐	☐
Have you been diagnosed with heart inflammation (myocarditis/pericarditis) after a previous dose of a COVID-19 vaccine?	☐	☐
PART B3: SPECIAL SITUATIONS (CAN STILL VACCINATE)	**NO**	**YES**
Have you ever had anaphylaxis to medications, insect stings, food, or unknown triggers	☐	☐
(For females) Are you pregnant or suspect that you are pregnant (late menstrual period)?	☐	☐
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)#	☐	☐
• Recent transplant in the past 3 months#	☐	☐
• Aggressive Immunotherapy for non-cancer conditions (e.g. rituximab etc)#	☐	☐

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**.

Memo from treating specialist is required to proceed with vaccination.

MOH MODERNA / SPIKEVAX COVID-19 VACCINATION FORM (ASSESSMENT CLINIC) – FORM 2
TO BE COMPLETED BY DOCTOR OR NURSE AT THE VACCINATION SITE

PART D: CLINICAL SAFETY REVIEW OF PATIENTS		
PART D1: NOT ELIGIBLE FOR MODERNA/SPIKEVAX **IF YES → DO NOT VACCINATE**	**NO**	**YES**
• Child under 6 months old	☐	☐
PART D2: CONTRAINDICATIONS TO COVID-19 VACCINE **IF YES → DO NOT VACCINATE**	**NO**	**YES**
• High-risk/immediate (onset ≤4h) allergic reaction or anaphylaxis to previous dose of same vaccine, or any of its components	☐	☐
• Myocarditis / pericarditis after a previous COVID-19 vaccine	☐	☐
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	☐	☐
PART D4: SPECIAL SITUATIONS → CAN VACCINATE	**NO**	**YES**
IF YES to being on anti-coagulation, has bleeding disorder or low platelets →		
• Advise to hold firm pressure at injection site for 5 minutes	☐	☐
IF YES to being/possibly pregnant →		
• Check if patient wishes to discuss with obstetrician (optional)	☐	☐
IF YES to any of the below, check if the suitability has been assessed by treating specialist		
• On cancer treatment (immunotherapy / chemotherapy / radiotherapy) less than 3 months ago or planned in the next 2 months	☐	☐
• Recent transplant in the past 3 months	☐	☐
• Aggressive immunotherapy for non-cancer conditions (e.g., rituximab, etc.)	☐	☐
IF YES to history of allergic reactions to other COVID-19 vaccines **OR** any anaphylaxis→		
• ENSURE POST-VACCINATION OBSERVATION PERIOD OF 30 MINUTES	☐	☐

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	Form Completed by _____ Name (stamp) / Signature / Date

PART E: VACCINATION RECORD			
COVID-19 vaccine given: ☐ #1 Date: ☐ #2 Date: ☐ #3 Date: ☐ #4 Date: ☐ #5 Date: ☐ #6 Date: *Please record any further doses, as applicable*	Injection site: ☐ Left deltoid ☐ Right deltoid ☐ Left thigh ☐ Right thigh ☐ Other_____	Vaccine Brand (*specify version): ☐ Pfizer-BioNTech/Comirnaty (Original / Bivalent / XBB.1.5)* ☐ Moderna/Spikevax (Original / Bivalent / XBB.1.5)* ☐ Sinovac-CoronaVac ☐ Novavax/Nuvaxovid ☐ 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 after vaccination (for syncope, anaphylaxis etc)[1] ☐ If allergic symptoms develop during observation, observe until stable or refer to ED	Time of vaccination:
Remarks by doctor (If treatment required):	Assessed by: _____ Name (stamp) / Signature / Date

[1] For persons with history of anaphylaxis or allergic reactions (<4h) to any other COVID-19 vaccines, observe for **30 min.**