

MOH PFIZER-BIONTECH / COMIRNATY 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):			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (dd/mm/yyyy):	Age:	Ethnic Group: <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Malay <input type="checkbox"/> Others	
Address*:		Postal Code:	Residential Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Long term <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other		
			Handphone Number: Email Address*:		
PART B: MEDICAL INFORMATION				<i>Waiting Area</i>	
PART B1: FEVER				NO	YES
Have you had a fever (temperature $\geq 37.5^{\circ}\text{C}$) in the past 24 hours?				<input type="checkbox"/>	<input type="checkbox"/>
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)				<input type="checkbox"/>	<input type="checkbox"/>
<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? 				<input type="checkbox"/>	<input type="checkbox"/>
Have you had any allergic reactions to other COVID-19 vaccines?				<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with heart inflammation (myocarditis/pericarditis) after a previous dose of a COVID-19 vaccine?				<input type="checkbox"/>	<input type="checkbox"/>
PART B3: 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"/>
(For females) Are you pregnant or suspect that you are pregnant (late menstrual period)?				<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking these medications or have these medical conditions?				<input type="checkbox"/>	<input type="checkbox"/>
<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)[#] • Recent transplant in the past 3 months[#] • Aggressive Immunotherapy for non-cancer conditions (e.g. rituximab etc)[#] 				<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		Date (dd/mm/yyyy)	
Signature					

* 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 PFIZER-BIONTECH / COMIRNATY 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 PFIZER-BIONTECH / COMIRNATY		
IF YES → DO NOT VACCINATE	NO	YES
• Child under 6 months old	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
• Myocarditis / pericarditis after a previous COVID-19 vaccine	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
PART D4: SPECIAL SITUATIONS → CAN VACCINATE		
IF YES to being on anti-coagulation, has bleeding disorder or low platelets →	NO	YES
• Advise to hold firm pressure at injection site for 5 minutes	<input type="checkbox"/>	<input type="checkbox"/>
IF YES to being/possibly pregnant →		
• Check if patient wishes to discuss with obstetrician (optional)	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
• Recent transplant in the past 3 months	<input type="checkbox"/>	<input type="checkbox"/>
• Aggressive immunotherapy for non-cancer conditions (e.g., rituximab, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
IF YES to history of allergic reactions to other COVID-19 vaccines OR any 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; 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		Form Completed by _____ Name (stamp) / Signature / Date
PART E: VACCINATION RECORD		
COVID-19 vaccine given: <input type="checkbox"/> #1 Date: <input type="checkbox"/> #2 Date: <input type="checkbox"/> #3 Date: <input type="checkbox"/> #4 Date: <input type="checkbox"/> #5 Date: <input type="checkbox"/> #6 Date: <i>Please record any further doses, as applicable</i>	Injection site: <input type="checkbox"/> Left deltoid <input type="checkbox"/> Right deltoid <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh <input type="checkbox"/> Other _____	Vaccine Brand (*specify version): <input type="checkbox"/> Pfizer-BioNTech/Comirnaty (Original / Bivalent / XBB.1.5)* <input type="checkbox"/> Moderna/Spikevax (Original / Bivalent / XBB.1.5)* <input type="checkbox"/> Sinovac-CoronaVac <input type="checkbox"/> Novavax/Nuvaxovid <input type="checkbox"/> Other _____
		Batch number: Bottle number (if applicable):
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 after vaccination (for syncope, anaphylaxis etc) ¹ <input type="checkbox"/> 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**.