MINISTRY OF HEALTH
SINGAPORE

MOH MODERNA COVID-19 VACCINATION FORM - FORM 1

TO BE COMPLETED BY PATIENT (please approach our staff if you need help)

卫生部莫德纳(MODERNA)2019冠病疫苗接种表格 – 表格 1

此表格由病患填写（如需协助，请向我们的职员求助）

MODERNA

PART A: PERSONAL PARTICULARS
A部分：个人资料

Queue 等候 *Registration* 登记

NAME (BLOCK LETTERS):
姓名（大写）：

NRIC No./Foreign Identification No.(FIN):
身份证/外国身份证号码：

Gender: 性别： ☐ Male 男 ☐ Female 女	**Date of Birth (dd/mm/yyyy):** 出生日期（日/月/年）： ☐☐/☐☐/☐☐☐☐	**Age:** 年龄：	**Ethnic Group:** 种族： ☐ Chinese 华族 ☐ Indian 印族 ☐ Malay 马来族 ☐ Others 其他

Residential Status:
居民身份：
☐ Citizen 公民 ☐ Long term 长期准证持有者
☐ Permanent Resident 永久居民 ☐ Other 其他

Address*:
住址*：

Postal Code:
邮政编号:

Handphone Number:
手机号码：

Email Address*:
电邮*：

PART B: MEDICAL INFORMATION
B部分：医疗信息

Waiting Area 等候区

PART B1: FEVER B1部分：发烧	**NO** 否	**YES** 是
Have you had a fever (temperature ≥ 37.5°C) in the past 24 hours? 你在过去24小时内是否有发烧（体温达37.5°C或以上）？	☐	☐

PART B2: ADVERSE EVENTS TO VACCINES B2部分：疫苗引起的不良反应	**NO** 否	**YES** 是
Have you ever had any allergic reactions to VACCINES: 你是否曾对任何疫苗产生过敏反应？		
• Anaphylaxis: severe reaction with two or more of the following: (a) hives or face/eyelid/lip/throat swelling, (b) difficulty breathing, (c) dizziness 过敏性休克：严重的过敏性反应，并出现两个或多个下列症状：(a) 荨麻疹或脸部/眼皮/嘴唇/喉咙肿胀，(b) 呼吸困难，(c) 晕眩	☐	☐
• Have you had rash OR hives OR face/eyelid/lip swelling to VACCINES? 你是否在注射疫苗后出现过皮疹或荨麻疹或脸部/眼皮/嘴唇肿胀的症状？	☐	☐
Have you been diagnosed with heart inflammation (myocarditis/pericarditis) after a previous dose of a COVID-19 vaccine? 你是否曾在注射冠病疫苗之后，被诊断出患有心肌炎或心包炎？	☐	☐

PART B3: SPECIAL SITUATIONS (CAN STILL VACCINATE) B3部分：特殊情况（仍可接种疫苗）	**NO** 否	**YES** 是
Have you ever had anaphylaxis to medications, insect stings, food or unknown triggers? 你是否曾因药物、蚊虫叮咬、食物或不明原因而出现过敏性休克反应？	☐	☐
(For females) Are you pregnant or suspect that you are pregnant (late menstrual period)? （女性回答）你是否怀孕或认为自己可能怀孕（月经延迟）？	☐	☐
Are you currently taking these medications or have these medical conditions? 你目前是否正在服用以下药物或有以下病症？		
• Blood-thinning medications (e.g. warfarin, apixaban, rivaroxaban, etc.) 血液稀释药物（如华法林、阿哌沙班、利伐沙班等）	☐	☐
• Bleeding disorder or low platelets 出血性疾病或血小板计数低	☐	☐

• On cancer treatment (immunotherapy / chemotherapy / radiotherapy in the past 3 months **OR** planned in the next 2 months)# 接受癌症治疗（在过去三个月接受过**或**计划在接下来两个月内接受免疫疗法/化疗/放射治疗）#	☐	☐
• Recent transplant in the past 3 months# 在过去三个月内进行过移植手术#	☐	☐
• Aggressive Immunotherapy for non-cancer conditions (e.g. rituximab, etc.)# 接受治疗非癌症疾病的激烈免疫疗法（如利妥昔单抗等）#	☐	☐

PART C: PATIENT DECLARATION AND CONSENT
C部分：病患声明与意愿

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.

我声明，我所提供的信息完整及正确无误。
我已了解接种2019冠病疫苗的风险、好处和副作用并愿意接种2019冠病疫苗。

☐ I **AGREE** to receive COVID-19 vaccination; OR
我**同意**接种2019冠病疫苗；或

☐ I **DO NOT** wish to receive COVID-19 vaccine**
我**不要**接种2019冠病疫苗**

_____	_____	_____	_____
Name of patient / parent / guardian 病患/病患父母或监护人姓名	NRIC No. / FIN 身份证/外国身份证号码	Signature 签名	Date (dd/mm/yyyy) 日期（日/月/年）

* 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.
* 通过点名单、预约系统提交姓名的病患及加入自我疫苗接种活动的医疗人员无须填写。
** 若病患**不要**接种2019冠病疫苗，则无须填写**表格2**。
# 病患须持有主治专科医生的医生证明，才能接种疫苗。

MOH MODERNA COVID-19 VACCINATION FORM (ASSESSMENT CLINIC) – FORM 2

TO BE COMPLETED BY DOCTOR OR NURSE AT THE VACCINATION SITE

卫生部莫德纳(MODERNA)2019冠病疫苗接种表格（评估诊所）－表格 2

此表格由在疫苗接种地点的医生或护士填写

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 18 years	☐	☐
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	☐	☐
• Allergy or anaphylaxis to other (non-COVID-19) vaccines → Refer to allergist*	☐	☐
PART D4: SPECIAL SITUTATIONS → 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	☐	☐
IF YES to being/possibly pregnant →		
• Check if patient wishes to discuss with obstetrician (optional)	☐	☐
IF YES to any of the below, check if 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 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 ☐ Allergy or anaphylaxis to other vaccines → Refer to allergist*	Form Completed by _____ Name (stamp) / Signature / Date

PART E: VACCINATION RECORD			
COVID-19 vaccine given: ☐ #1 Date: ☐ #2 Date: ☐ #3 Date:	Injection site: ☐ Left deltoid ☐ Right deltoid ☐ Other_____	Vaccine Brand: ☐ Pfizer-BioNTech / Comirnaty ☐ Moderna ☐ Sinovac ☐ 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 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.