HEALTH DECLARATION SCREENING FORM FOR PFIZER

*of the Philippine National COVID-19 Vaccine Deployment and Vaccination Program as of June 9, 2021*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ASSESS THE PATIENT** | | | **NO** | | **YES** |
| Below 16 years old? | | |  | |  |
| Had a severe allergic reaction to any ingredient of the PFIZER vaccine: *mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene*  *glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose?* | | |  | |  |
| Had a severe allergic reaction or an autoimmune reaction (i.e Vaccine-Induced Thrombotic Thrombocytopenia) after the 1st dose of the PFIZER vaccine? | | |  | |  |
| Has allergy to food, egg, medicines and/or with asthma?  *Other allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*   * If with allergy or asthma, will monitoring the patient for 30 minutes be a problem? | | |  | |  |
|  |
| Has history of bleeding disorders or currently taking anti-coagulants?   * If with bleeding history or currently taking anti-coagulants, is there a problem in securing a gauge 23 - 25 syringe for injection? | | |  | |  |
|  | |  |
| Manifests any one of the following symptoms?   * Fever/chills ❑ Fatigue * Headache ❑ Weakness * Cough ❑ Loss of smell/taste * Colds ❑ Diarrhea * Sore throat ❑ Shortness of breath/diﬃculty in breathing * Myalgia ❑ Nausea/Vomiting * Rashes ❑ Other symptoms of existing comorbidity | | |  | |  |
| Current medication/s : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |  | | |
| Has history of hypertension (*high blood pressure*)? | | |  | |  |
| * If with history of hypertension, does the person currently have SBP>180 and/or dBP >120, with signs and symptoms of organ damage? | | |  | |  |
| Has history of exposure to a conﬁrmed or suspected COVID-19 case in the past 14 days? | | |  | |  |
| If previously diagnosed with COVID-19, is STILL undergoing recovery or treatment? | | |  | |  |
| Has received any vaccine in the past 14 days, or plans to receive another vaccine 14 days following vaccination? | | |  | |  |
| Has received convalescent plasma or monoclonal antibodies for COVID-19 in the past 90 days? | | |  | |  |
| Are you pregnant?   * If pregnant, are you in the 1st trimester? **LMP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |  | |  |
|  | |  |
| Has any of the following diseases or health condition?   * HIV * Cancer/ Malignancy y and is currently undergoing chemotherapy, radiotherapy, immunotherapy or other treatment * Underwent Transplant * Under Steroid Medication/ Treatment * Bed ridden, terminal illness, less than 6 months prognosis * Autoimmune disease   If with any of the abovementioned condition, is there any objection to vaccination from presented medical clearance  **prior** to vaccination day? | | |  | |  |
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*\* Please keep this health screening form as part of the patient’s oﬃcial vaccination and medical record.*

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| **Recipient’s Full Name:**  **(LAST NAME, FIRST NAME, MIDDLE NAME)** | |  | | **Recipient’s Name:** | | |
| **Birthdate:** | **Sex:** | | **Birthdate:** | | **Sex:** |
| **Name and Signature of Health Worker:** | |  | | **Name and Signature of Health Worker:** | | |

**VACCINATE**

If any of the non-gray responses is checked, defer vaccination

If vital signs are taken, pls. record them here: Time: BP: HR: RR: Temp. O2 sat: