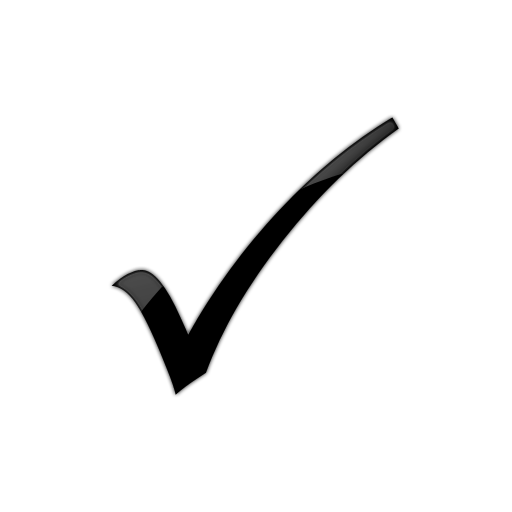
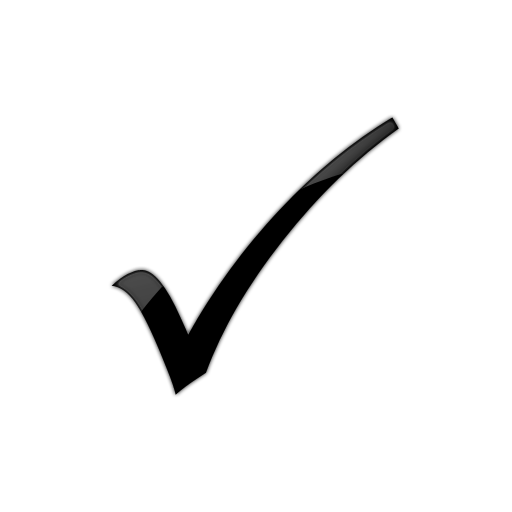
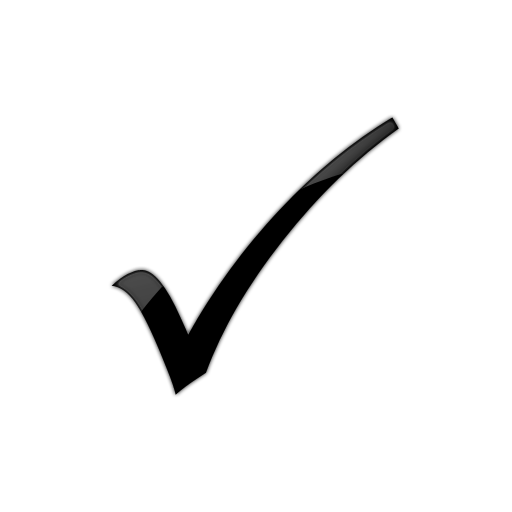
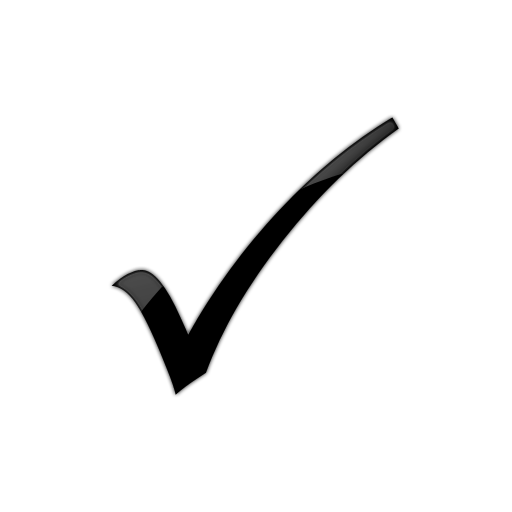
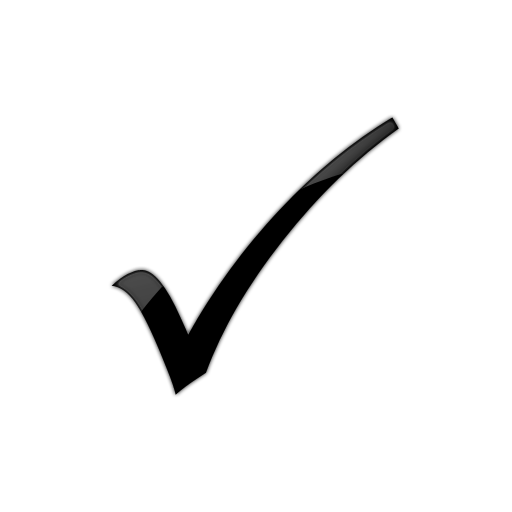
**HEALTH ASSESSMENT FORM**

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**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONTACT NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

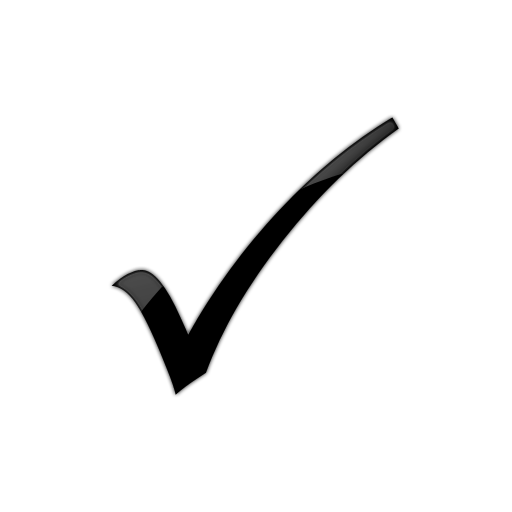
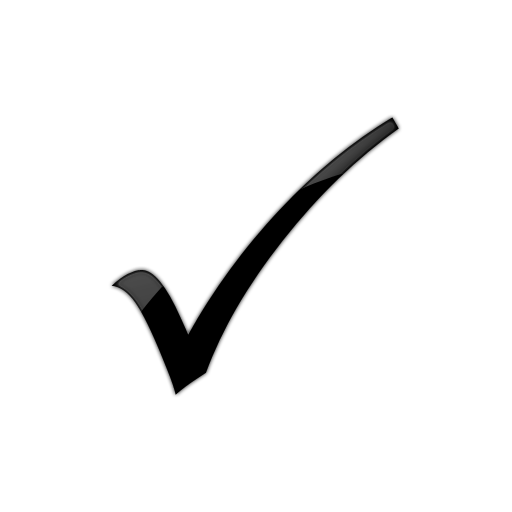
**INITIAL VITAL SIGNS:**

Temperature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pulse Rate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Pressure :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ O2 Sat:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Respiratory Rate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Markahan ng (✓) ang sagot sa mga sumusunod na katanungan. | **YES** | **NO** |
| 1.Are you experiencing (nakakaranas ka ba ng): |  |  |
| a) Sore Throat *(Pananakit ng lalamunan/masakit lumunok)* |  |  |
| b) Body Pain *(Pananakit ng katawan)* |  |  |
| c) Headache *(Pananakit ng ulo)* |  |  |
| d) Fever for the past 2 weeks *(Lagnat sa nakalipas 2 linggo)* |  |  |
| 2. Have you worked together or stayed in the same close environment with a confirmed COVID-19 case under self-quarantine in your house or in your neighborhood?  *(May nakasama ka ba o nakatrabahong tao na kumpirmadong may COVID-19/ may impeksyon ng coronavirus na kasama mo naka quarantine sa bahay o sa kapitbahay?)* |  |  |
| 3. Have history of allergies (food/medicines/etc) If YES, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 4. History of Asthma? If YES, date of last attack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 5. Have you travelled outside of the Philippines in the last 14 days? *(Ikaw ba ay nagbiyahe sa labas ng Pilipinas sa nakalipas na 14 na araw?)* |  |  |
| 6. Currently taking any medication? If YES please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 7. Are you currently having the following conditions:  (*Sa kasalukuyan, ikaw ba ay mayroon ng mga sumusunod na kundisyon)* |  |  |
|  60 years old and above (*May edad na 60 taong gulang o pataas)* |  |  |
|  Ongoing pregnancy (*Nagbubuntis)* |  |  |
|  Hypertension (*Mataas ang presyon ng dugo)* |  |  |
|  Heart disease (*Sakit sa puso)* |  |  |
|  Diabetes Mellitus (*Diabetes)* |  |  |
|  Recurrent asthma attacks (*May hika)* |  |  |
|  Chronic lung disease- ongoing PTB treatment (S*akit sa baga - ginagamot sa tuberculosis o TB)* |  |  |
|  COPD *(Chronic Obstructive Pulmonary Disease)* |  |  |
|  Cancer (*Kanser)* |  |  |
|  Blood Dyscrasias (*Sakit sa dugo)* |  |  |
|  Chronic Liver and Kidney diseases (*Sakit sa atay at bato)* |  |  |
|  Immunocompromised Status (*Sobrang mahina ang resistensya)* |  |  |
| Vaccination site preferred: DELTOID RIGHT LEFT |  |  |
| I hereby give my consent to be vaccinated with the SINOVAC Vaccine. |  |  |

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature over Printed Name**  **Date**