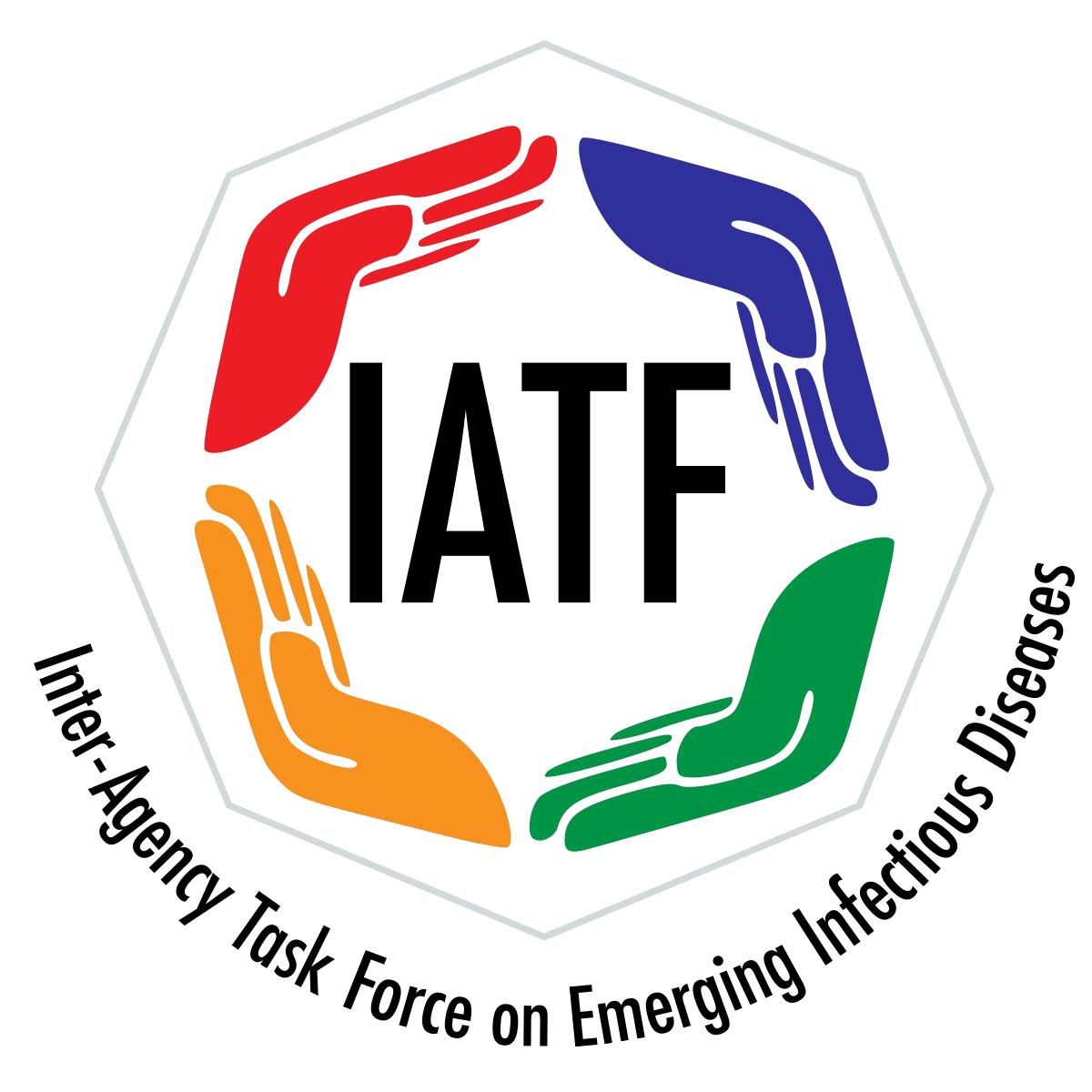
**HEALTH DECLARATION SCREENING FORM FOR SINOVAC

*of the Philippine National COVID-19 Vaccine Deployment and Vaccination Program*

*as of April 15, 2021*

|  |  |  |
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| **ASSESS THE PATIENT** | **NO** | **YES** |
| Below 18 years old? |  |  |
| Has severe allergic reaction after the 1st dose of the SINOVAC 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 an available gauge 23 - 25 syringe for injection? |  |  |
|  |  |
| Manifests any 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 : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Currently with 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 2 weeks (14 days)? |  |  |
| If previously diagnosed with COVID-19, is still undergoing recovery or treatment? |  |  |
| Has had attacks, admissions, or changes in medication for the past 3 months? |  |  |
| Has received any other 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 * Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   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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| **Recipient’s Full Name:**  **(LAST NAME, FIRST NAME, MIDDLE NAME)** | |
| **Birthdate:** | **Sex:** |
| **Name and Signature of Health Worker:** | |

**VACCINATE**

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