ANNEX B. INFORMED CONSENT FORM

INFORMED CONSENT FORM FOR SECOND ADDITIONAL/BOOSTER DOSE OF COVID-19 VACCINE
of the Philippine National COVID-19 Vaccine Deployment and Vaccination Program as of April 20, 2022

Name:		**Birthdate:**	**Sex:**
Address:			
Occupation:		**Contact Number:**	
Health facility:		**Primary COVID-19 Vaccine Series:**	

INFORMED CONSENT

I confirm that I have been provided with and have read the COVID-19 Vaccine AstraZeneca / Janssen / Moderna / Pfizer / Sinopharm / Sinovac / Sputnik Light Emergency Use Authorization (EUA) Information Sheet and the same has been explained to me. The FDA has amended the Emergency Use Authorization for these COVID-19 Vaccines to allow its use as second additional/booster dose for specific populations in light of new scientific evidence.

I confirm that I have been screened for conditions that may merit deferment or special precautions for additional/booster dose vaccination as indicated in the Health Screening Questionnaire.

I have received sufficient information on the benefits and risks of receiving a additional/booster dose of the COVID-19 vaccine and I understand the possible risks if I am not vaccinated with an additional/booster dose.

I was provided an opportunity to ask questions, all of which were adequately and clearly answered. I, therefore, voluntarily release the Government of the Philippines, the vaccine manufacturer, their agents and employees, as well as the hospital, the medical doctors and vaccinators, from all claims relating to the results of the use and administration of, or the ineffectiveness of a additional/booster dose of COVID-19 vaccines.

I understand that while most side effects are minor and resolve on their own, there is a small risk of severe adverse reactions, such as, but not limited to allergies and blood clots associated with low platelet counts (vaccine-induced thrombotic thrombocytopenia), heart conditions (e.g. myocarditis and pericarditis). Should prompt medical attention be needed, referral to the nearest hospital shall be provided immediately by the Government of the Philippines. I have been given contact information for follow up for any symptoms which I may experience after vaccination.

I understand that by signing this Form, I have a right to health benefit packages under the Philippine Health Insurance Corporation (PhilHealth), in case I suffer a severe and/or serious adverse event, which is found to be associated with these COVID-19 vaccine or its administration. I understand that the right to claim compensation is subject to the guidelines of the PhilHealth.

I authorize releasing all information needed for public health purposes including reporting to applicable national vaccine registries, consistent with personal and health information storage protocols of the Data Privacy Act of 2012.

I hereby give my consent to receive a second additional/booster dose of the COVID-19 Vaccine AstraZeneca / Janssen / Moderna / Pfizer / Sinopharm / Sinovac / Sputnik Light.

_____ _____

Signature over Printed Name | Date

In case eligible individual is unable to sign:
I have witnessed the accurate reading of the consent form and liability waiver to the eligible individual; sufficient information was given and queries raised were adequately answered. I hereby confirm that he/she has given his/her consent to be vaccinated with the COVID-19 Vaccine AstraZeneca / Janssen / Moderna / Pfizer / Sinopharm / Sinovac / Sputnik Light.

_____ _____

Signature over Printed Name | Date

If you chose not to get a second additional/booster dose vaccine, please list down your reason/s:

ANNEX C. HEALTH DECLARATION FORM

COVID-19 SECOND ADDITIONAL/BOOSTER DOSE VACCINATION HEALTH DECLARATION SCREENING FORM

of the Philippine National COVID-19 Vaccine Deployment and Vaccination Program as of April 20, 2022.

ASSESS THE PATIENT	NO	YES
Has received more than one booster dose?	❑	❑
Has it been less than four (4) months since the last booster dose?	❑	❑
Below 18 years old?	❑	❑
Had a severe allergic reaction to any ingredient of the vaccine currently being offered? Or had a severe allergic reaction after receiving any COVID-19 vaccine?	❑	❑
Has allergy to food, egg, medicines? Has asthma?	❑	❑
➢ 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 securing a gauge 23 - 25 syringe for injection?	❑	❑
Has SBP ≥160 mmHg and/or DBP≥ 100 mmHg WITH signs and symptoms of organ damage?	❑	❑
If initially with SBP ≥160 mmHg and/or DBP≥ 100 mmHg WITHOUT signs and symptoms of organ damage, is there a problem maintaining a blood pressure of <160/100 mmHg after monitoring two times every fifteen minutes?	❑	❑
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	❑	❑
Has history of exposure to a confirmed or suspected COVID-19 case in the past 14 days?	❑	❑
If previously diagnosed with COVID-19, is recipient STILL undergoing recovery or treatment?	❑	❑
Has received any vaccine in the past 14 days or plans plan to receive another vaccine 14 days following vaccination?	❑	❑
Has received convalescent plasma or monoclonal antibodies for COVID-19 in the past 90 days?	❑	❑
If in the 1st trimester of pregnancy, is there any objection to vaccination from the presented medical clearance from the attending physician?	❑	❑
Has any of the following diseases or health conditions? ❑ HIV ❑ Cancer/Malignancy and currently undergoing chemotherapy, radiotherapy, immunotherapy or other treatment ❑ Underwent transplant ❑ Under steroid treatment or medication ❑ Bed ridden, terminal illness, less than 6 months prognosis ❑ With autoimmune disease	❑	❑
➢ If with any of the abovementioned condition, is there any objection to vaccination from presented medical clearance **prior** to vaccination day?	❑	❑

Recipient's Name:						
Priority Group:	A1	A2	A3	A4	A5	ROAP
Birthdate:					**Sex:**	
Name and Signature of Health Worker:						

VACCINATE

If any of the **white** boxes is checked, **DEFER** vaccination

* Please keep this health screening form as part of the patient's official vaccination and medical record.