matilda International Hospital 明德國際醫院

Affix Patient's Label here

Questionnaire for COVID-19 Vaccine (CoronaVac)

Please complete the following prior to vaccination by ticking the appropriate boxes.

	Yes	No
1. Do you suffer from any acute illness?		
2. Do you have a history of allergic reactions to any component (active or inactive ingredients*) of CoronaVac vaccine or similar vaccines?		
3. Do you have a history of severe allergic reactions to other vaccines or medications (e.g. acute anaphylaxis, angioedema, dyspnea, etc.)?		
4. Do you suffer from any uncontrolled severe chronic diseases?		
5. Have you suffered from any severe neurological conditions (e.g. transverse myelitis, Guillain-Barré syndrome, demyelinating diseases, etc.) before?		
6. Do you suffer from diabetes, convulsions, epilepsy, encephalopathy, have a mental illness history or family history?		
7. Do you suffer from thrombocytopenia or any bleeding disorders, or receive anticoagulants?		
8. Do you have a history of cardiovascular or cerebrovascular disease (e.g. Stroke, mini-stroke, heart attack, etc.)?		
9. Are you immunocompromised (e.g. HIV, receiving immunosuppressive therapy e.g. chemotherapy, antimetabolic drugs, alkylating agents, cytotoxic drugs, corticosteroid drugs, etc.)?		
10. Have you received human immunoglobulin in the past month?		
11. Have you recently received any other vaccines?		
12. (For female patient only) Are you pregnant or breast-feeding?		
13. Do you wish to consult a doctor before vaccination?		

**Including Inactivated SARS-CoV-2 Virus (CZ02 strain), aluminium hydroxide, disodium hydrogen phosphate dodecahydrate, sodium dihydrogen phosphate monohydrate, and sodium chloride.*

I consent to the administration of COVID-19 Vaccination under the COVID-19 Vaccination Programme.

Signature of Client/ Parent/ Guardian*
** Please delete as appropriate*

Signature of Nurse

(If there is any YES in the above questions; or never had influenza vaccination before; or NEW client without referral, a doctor's consultation is required for approval)

Applicable to staff only:

☐ *I consent to update MIH staff health database of my COVID-19 vaccination status*

Administration of Vaccination					
Date & Time:		Batch No.:			
Site:	☐left deltoid ☐right deltoid	Checked by:		Given by:	

matilda International Hospital 明德國際醫院

Affix Patient's Label here

2019 冠狀病毒病疫苗問卷
(克爾來福)

在接種疫苗前，請在相應的方框中打剔。

	是	否
1. 你是否患有急性疾病?		
2. 你曾否對克爾來福疫苗或類似疫苗的任何成分（活性成分或非活性成分*）有過敏反應？		
3. 你曾否對其他疫苗或藥物有嚴重過敏反應（例如急性過敏反應，血管神經性水腫，呼吸困難等）？		
4. 你是否患有任何未受控制的嚴重慢性疾病？		
5. 你曾否患有任何嚴重的神經系統疾病（例如橫貫性脊髓炎，格林巴利綜合症，脫髓鞘疾病等）？		
6. 你是否有糖尿病、驚厥、癲癇、腦病、精神疾病史或家族史？		
7. 你是否患有血小板減少症或任何出血性疾病，或正在接受抗凝劑？		
8. 你是否有心血管或腦血管疾病的病史(例如中風，小中風，心臟病發等）？		
9. 你的免疫功能有否受損（例如愛滋病，正在服用具有免疫抑制作用的藥物，例如化療藥物，抗代謝藥物，烷化劑，細胞毒素類藥物，皮質類固醇類藥物等）？		
10. 在過去的一個月中，你曾否注射過人類免疫球蛋白？		
11. 你最近曾否接種過其他疫苗？		
12.（只適用於女性）你是否正在懷孕或哺乳？		
13. 你是否希望在接種疫苗前諮詢醫生？		

* 包括：滅活的新型冠狀病毒(CZ02 株)、氫氧化鋁佐劑、磷酸氫二鈉十二水合物、磷酸二氫鈉一水合物、氯化鈉。

我同意在 2019 冠狀病毒病疫苗接種計劃下接種 2019 冠狀病毒病疫苗。

_____ _____

客戶/ 父母/ 監護人簽署* 護士簽署

*請刪去不適用者

如果以上問題中有“是”；或以前從未接種過流感疫苗；或未有醫生轉介的新客戶，需先進行醫生諮詢。

僅適用於員工:

☐ 我同意在明德醫院員工健康數據庫中更新我的 2019 冠狀病毒病疫苗接種狀況

Administration of Vaccination					
Date & Time:		Batch No.:			
Site:	☐left deltoid ☐right deltoid	Checked by:		Given by:	