

CHEVRAH KADISHA COVID-19 VACCINATION CENTRE HEALTH BACKGROUND

(This information will be captured directly onto the government vaccination portal)

First name	
Surname	
ID / Passport number	

1. Are you sick today?
 Yes No

1.1. If Yes, please provide details:

2. Have you received any vaccinations in the past 2 weeks?
 Yes No

2.1. If Yes, please indicate what vaccine:

3. Have you received any other COVID-19 vaccine at any time?
 Yes No

3.1	If Yes, please provide the date of vaccination: <small>YYYY-MM-DD</small>	Where did you receive the vaccine? (e.g. which clinic?):										
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4. Have you been diagnosed with COVID-19 infection in the last 90 days?
 Yes No

4.1 If Yes, what date did you test positive? YYYY-MM-DD

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5. Do you have a history of an anaphylactic reaction to anything other than a vaccine or injectable medication?
 Yes No

5.1. If Yes, please describe:

6. Have you ever had an anaphylactic reaction: Trouble breathing?
 Yes No

7. Have you ever had an anaphylactic reaction: Broke out into hives?
 Yes No

8. Have you ever had an anaphylactic reaction: Facial or tongue swelling?
 Yes No

9. Have you ever had an anaphylactic reaction: Low blood pressure?
 Yes No

10. Have you ever had an anaphylactic reaction: Other severe symptoms after receiving another vaccination or injection (a shot given intravenously, intramuscularly, or subcutaneously)?
 Yes No

11. Do you have any chronic conditions?
 Yes No

11.1. If Yes, which chronic condition? Please specify:

- TB
- HIV
- Hypertension
- Diabetes
- Heart disease
- Chronic lung disease
- Cancer
- Other (specify in 11.1.1.)

11.1.1. If Other, please specify:

12. Female vaccine recipient only: Do you suspect that you might be pregnant today?
 Yes No Male – Not applicable

12.1 If Yes or unknown, please indicate when you had your last menstrual period. YYYY-MM-DD

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Signed at Sandringham Gardens, on this _____ day of _____ 2022.

Signature: _____

First name and surname: _____

