COVID-19 vaccination Consent Form

I am voluntarily getting the COVID-19 vaccine. The COVID-19 vaccine was produced by (Please choose one of the vaccine types)

☐Oxford/ AstraZeneca. Product Name: COVISHIELD,

☐ Sinopharm. Product Name: BBIBP-CorV,

☐ Other (Specify:_____)

which is under the responsibility of the Ministry of Health, Lao PDR.

I am aware that this vaccine has been given to people in many countries. It is an emergency vaccination to be used for preventing and controlling the COVID-19 pandemic. I have read and acknowledged the detail of this vaccine. I also had the opportunity to review all the information, concerns and received complete answers about its benefits and its side effect that might occur after receiving this COVID-19 vaccine.

Therefore, I agree and voluntarily accept to be vaccinated.

Name and surname of vaccine recipient: _____Signature_____

Name and Surname of Health worker: _____Signature_____

COVID-19 Pre-Vaccination Enrollment Form

CVID (Vaccine ID)

H					-		-					
HFID					Team ID			Serial No.				

To be filled by a client

① Basic Info: First tell us who you are.

National ID/Passport no.: _____ First name:_____ Last name: _____

Sex: ☐ M ☐ F Date of birth: _____ /_____ /_____ Age: _____

Current address: Village (Stamped)[1]_____ District _____ Province _____

Occupation: ☐ Health ☐ Education ☐ Religion ☐ Private business

☐ Administerative ☐ Agriculture ☐ Finance ☐ Transportation ☐ Tourism ☐ Service ☐ Entertainment

☐Food ☐Manufacture ☐Construction ☐Others(specify)_____Employer: _____

Phone no.:_____

② Medical History: We need the following medical information for the registration.

1. Have you been infected by COVID-19? ☐ Yes ☐ No / If yes, date of complete recovery: _____ /_____ /_____

2. Do you have any of the following conditions? ☐ Yes ☐ No

☐ Chronic kidney disease	☐ Chronic liver disease	☐ Hypertension
☐ Diabetes	☐ Obesity (BMI 30 kg/m2 or higher)	☐ Down syndrome
☐ Chronic heart disease	☐ Cancer	☐ Others (specify) _____
☐ Chronic respiratory disease (excluding mild asthma)	☐ Immunocompromised (including solid organ transplant)	

[1] Write down only the name of a stamped village (an official village administered by a village head with a stamp)

③ Screening: We need to make sure that you can receive the vaccine, so please answer the following questions.

Screening Criteria/Questions	1st Dose		2nd Dose	
1. Are you under 18 years old?	☐ Yes	○ No	☐ Yes	○ No
2. Do you feel **sick** today?	☐ Yes	○ No	☐ Yes	○ No
3. Is your **current temperature** > 38.5 degrees Celcius?	☐ Yes	○ No	☐ Yes	○ No
4. Are you immuno-compromised or taking a medicine that affects the **immune system**?	☐ Yes	○ No	☐ Yes	○ No
5. Do you have a bleeding disorder, or taking a medicine that affects **blood clotting**?	☐ Yes	○ No	☐ Yes	○ No
6. Do you have a history of **convulsion, epilepsy,** or any other neurological disease?	☐ Yes	○ No	☐ Yes	○ No
7. Are you **breastfeeding, pregnant, or planning on becoming pregnant**?	☐ Yes	○ No	☐ Yes	○ No
8. Have you had a severe **allergic reaction** following previous vaccinations?	☐ Yes	○ No	☐ Yes	○ No
9. Have you received **any other vaccines within the past 14 days?**	☐ Yes	○ No	☐ Yes	○ No

To be filled by a health care worker

1. Target Group Segment:

☐ Healthcare worker; ☐ Essential worker; ☐ Essential traveler; ☐ Underlying conditions;
☐ Elderly (≥60 years old); ☐ Others

2. Vital signs measurement

2.1) Temperature_____ 2.2) Blood pressure_____ 2.3) others_____

3. Eligibility:

- If all the screening question (1-9) answers are "No," the person is eligible.
- If there is any "Yes" answer, consult/discuss eligibility and risk before the vaccination.
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- Is this client eligible for 1st Dose of vaccination? ☐ Yes ○ No
- Is this client eligible for 2nd Dose of vaccination? ☐ Yes ○ No

Vaccination Record

Dose (1st/2nd)	Product name/ Manufacturer	Vaccine batch number	Vaccination date (d/m/y)	Vaccination site	Name of Vaccinator
1st Dose					
2nd Dose					

AEFI (during the post vaccination observation)

Dose (1st/2nd)	AEFI observed/occurred?	If yes, Anaphylaxis?
1st Dose	☐ Yes ○ No	☐ Yes ○ No
2nd Dose	☐ Yes ○ No	☐ Yes ○ No