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**CERTIFICATION OF MEDICAL INELIGIBILITY FOR mRNA COVID-19 VACCINES**

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| --- | --- | --- | --- | --- | --- | --- |
|  |  | | | | | |
| Full Name  (as per NRIC/FIN/Passport): | |  | | | |  |
|  | |  |  |  |  | |
| NRIC/FIN/Passport Number: | |  | | | |  |
|  | |  | | | |  |
| Contact Number | |  | | | |  |
|  | |  | | | | |

To whom it may concern,

This is to certify that the above-mentioned person is medically ineligible for mRNA COVID-19 vaccines because he/she is a:

(Please tick where appropriate)

Person who developed an allergic reaction to a previous dose of any mRNA COVID-19 vaccine; or

Person who developed myocarditis or pericarditis following administration of any mRNA COVID19 vaccine; or

Person who developed a severe adverse reaction to a previous dose of any mRNA COVID-19 vaccine and had been determined that he/she should not receive a second mRNA vaccine dose; or

Person who has not taken any COVID-19 mRNA vaccine but has been determined to be allergic to polyethylene glycol (PEG)/ polysorbate through a positive skin prick/ intradermal test; or

Person with/ under the following condition(s)/ treatment[[1]](#footnote-1):

Transplant within past 3 months; and/or

Aggressive immunotherapy; and/or

Active cancer on treatment.

Please indicate the date when the above criteria will cease (where applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| Additional comments: |

Thank you.

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| Stamp/ Signature/ Date: |

|  |  |  |
| --- | --- | --- |
| Name and MCR No of Certifying Medical Practitioner: |  |  |
|  |  |  |
| Clinic/ Hospital Name: |  |  |
|  |  |  |
| Contact Number: |  |  |

1. Refers to patients in the listed groups who have been previously assessed by a doctor to be unsuitable to take the mRNA COVID-19 vaccines. This is however not an absolute contraindication to mRNA COVID-19 vaccinations. Please refer to MOH Circular No. 101/2021 for updated recommendations on contraindications and indications to mRNA COVID-19 vaccines. [↑](#footnote-ref-1)