

ADDENDUM FOR CHILD HEALTH BOOKLET

Please take care of this booklet and bring it along
whenever your child visits a doctor, nurse
or other healthcare professionals.

November 2021

Dear Parents/Guardians

This addendum modifies and supplements any Child Health Booklet(s) printed prior to November 2021.

Wherever there is any difference in content between this addendum and the older version(s) of the Child Health Booklet, the information within this addendum will supersede that in the older versions of the Child Health Booklet.

This addendum comprises the key pages that have been updated or added. The 'Contents of Addendum' page provides a summary of the sections where parents/guardians/clinicians should refer to the addendum.

Health Promotion Board

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SUMMARY OF RECOMMENDED TOUCHPOINTS FOR CHILDHOOD DEVELOPMENTAL SCREENING AND NCIS VACCINATIONS

AGE	TYPE OF SCREENING [^]	IMMUNISATION
At Birth	-	BCG (Dose 1) Hep B (Dose 1)
4 weeks	1. Growth monitoring: weight, length, OFC* 2. Feeding history 3. Hearing screening if not done at birth 4. Physical examination and developmental check on page 7 - 8 <ul style="list-style-type: none"> • To also focus on identifying any issues related to: <ul style="list-style-type: none"> (i) Congenital cataract (ii) Cardiac murmurs (iii) Prolonged jaundice (iv) Hip dysplasia (v) Abnormal growth monitoring (vi) Feeding issues (e.g. parent reported difficulties with breast or bottle feeding, vomiting/reflux) 	-
2 months	-	6-in-1 (Dose 1)**
3 months	1. Growth monitoring: weight, length, OFC* 2. Feeding history 3. Test for squint 4. Hearing screening if not done at birth/4-8 weeks 5. Parents/caregivers please answer the questions below***:	-
OR		
4 months	<ul style="list-style-type: none"> • Can your child keep his/her head upright when held in a sitting position? Yes/No • Can your child respond to the parent's/caregiver's voice by quietening down if crying or smiling? Yes/No • Can your child visually follow the parent's/caregiver's movements, including turning his/her head from side to side? Yes/No 6. Physical examination and developmental check on page 9 - 11	5-in-1 (Dose 2) PCV (Dose 1)
6 months	1. Growth monitoring: weight, length, OFC* 2. Feeding history 3. Parents/caregivers please answer the questions below***: <ul style="list-style-type: none"> • Can your child roll over? Yes/No • Can your child turn towards a sound? Yes/No • Can your child reach out for things? Yes/No 4. Physical examination and developmental check on page 12 - 14	6-in-1 (Dose 3) PCV (Dose 2) Influenza****

Legend: [^]The recommended CDS touchpoints are at 4 weeks, 3 months or 4 months, 6 months, 12 months, 18 months, 30 months and 48 months. For the second touchpoint, the recommended touchpoint is at 3 months for children starting on the 5-in-1 vaccine schedule and 4 months for children starting on the 6-in-1 vaccine schedule. The 5-in-1 vaccine includes DTaP, IPV and Hib. The 6-in-1 vaccine comprises components in 5-in-1 plus HepB. Refer to Section 3 for more information on immunisation.

* OFC - Occipito-Frontal Circumference

All height, weight and OFC measurements must be charted into the appropriate growth charts

** For infants born to **HBsAg +ve** mothers, HepB dose 2 is recommended at **1 month** using monovalent HepB vaccine. 5-in-1 dose 1 is recommended at 2 months.

*** If your answer to any of these questions is 'No', please inform your doctor.

**** Annual flu vaccination or per season for all children age **6 months to <5 years (59 months)**.

SUMMARY OF RECOMMENDED TOUCHPOINTS FOR CHILDHOOD DEVELOPMENTAL SCREENING AND NCIS VACCINATIONS

AGE	TYPE OF SCREENING [^]	IMMUNISATION
12 months	1. Growth monitoring: weight, length, OFC* 2. Feeding history 3. Test for squint 4. Parents/caregiver please answer the questions below***: <ul style="list-style-type: none"> • Can your child wave bye-bye or clap hands? Yes/No • Can your child say Papa or Mama? Yes/No • Can your child stand alone for 2 or more seconds without support? Yes/No • Can your child walk a few steps? Yes/No • Does your child have a pincer grasp? Yes/No • Does your child babble, point or use gestures? Yes/No • Does your child respond readily to affection? Yes/No 5. Physical examination and developmental check on page 15 – 17	PCV (Booster 1) MMR (Dose 1) Varicella (Dose 1)
15 months	1. Growth monitoring: weight, height, OFC* 2. Physical examination and developmental check on page 18 – 20	MMRV (Dose 2)
18 months	1. Growth monitoring: weight, height, OFC* 2. Test for squint 3. Parents/caregivers please answer the questions below***: <ul style="list-style-type: none"> • Can your child stoop or bend to pick up a toy from the floor and return to a standing position without sitting down or touching the floor with his hands? Yes/No • Can you child say at least three words other than “Papa/Mama”, which mean the same things each time he uses them? Yes/No 4. Physical examination and developmental check on page 18 – 20	5-in-1 (Booster 1)
30 months	1. Growth monitoring: weight, height, OFC, BMI 2. Test for squint 3. Parents/Caregivers please answer the questions below***: <ul style="list-style-type: none"> • Can your child climb stairs without assistance? Yes/No • Can your child speak spontaneously in sentences with 4 syllables? Yes/No 4. Physical examination and developmental check on page 21 – 24	-
48 months	1. Growth monitoring: weight, height, BMI 2. Visual acuity and test for squint 3. Stereopsis 4. Physical examination and developmental check on page 25 – 28	-

Legend: **The recommended CDS touchpoints are at 4 weeks, 3 months or 4 months, 6 months, 12 months, 18 months, 30 months and 48 months.** For the second touchpoint, the recommended touchpoint is at 3 months for children starting on the 5-in-1 vaccine schedule and 4 months for children starting on the 6-in-1 vaccine schedule. The 5-in-1 vaccine includes DTaP, IPV and Hib. The 6-in-1 vaccine comprises components in 5-in-1 plus HepB. Refer to Section 3 for more information on immunisation.

* OFC – Occipito-Frontal Circumference

All height, weight and OFC measurements must be charted into the appropriate growth charts

** For infants born to **HBSAg +ve** mothers, HepB dose 2 is recommended at **1 month** using monoavalent HepB vaccine. 5-in-1 dose 1 is recommended at 2 months.

*** If your answer to any of these questions is 'No', please inform your doctor.

**** Annual flu vaccination or per season for all children age **6 months to <5 years (59 months).**

SCREENING AT 12 MONTHS (6 months - 12 months)

Date of Screening: _____ Age: _____ Main caregiver: _____

PARENTAL CONCERNS

Please inform your doctor if your child has ANY of these difficulties:

- Does not babble, point or use gestures by 12 months
- Has lost any language skills
- Does not respond readily to affection
- Has poor eye contact

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED

	YES	NO	Age (mths) when 90% achieve the milestone
Personal Social			
1 Your child displays excitement like kicking legs or moving arms, on seeing an attractive toy. (Excites at a toy)	<input type="checkbox"/>	<input type="checkbox"/>	5.5
2 Your child will try to get a toy that he enjoys when it is out of reach by stretching his arms or body. (Works for a toy out of reach)	<input type="checkbox"/>	<input type="checkbox"/>	6.5
3 Your child seems to be shy or wary of strangers. (Reacts to stranger)	<input type="checkbox"/>	<input type="checkbox"/>	10
4 When you face your child, say bye-bye and wave to him, he responds by waving his arm, hand or fingers without his hands or arms being touched. (Waves bye-bye)	<input type="checkbox"/>	<input type="checkbox"/>	10.5
5 When you clap your hands, your child responds by clapping his hands when you ask him to, without his hands or arms being touched. (Claps hands)	<input type="checkbox"/>	<input type="checkbox"/>	11
6 Your child can indicate what he wants without crying or whining. He may do this by pointing, pulling and making speech-like sounds or putting arms up to be carried without speaking. (Indicates wants by gestures)	<input type="checkbox"/>	<input type="checkbox"/>	13.5
Fine Motor-Adaptive			
7 When your child is on his back, his eyes and head will follow the movement of an object from one side, past the mid-line and right over to the other side. (Follows 180 degrees)	<input type="checkbox"/>	<input type="checkbox"/>	4.5
8 Your child is able to focus on small objects like a raisin, placed in front of him on the table. (Regards a raisin)	<input type="checkbox"/>	<input type="checkbox"/>	5.5
9 Your child can pick up a toy within his reach or reach out for things. (Reaches for an object)	<input type="checkbox"/>	<input type="checkbox"/>	6
10 Your child will look for an object that has fallen out of his line of vision when his attention is focused on that object. (Looks for a fallen object)	<input type="checkbox"/>	<input type="checkbox"/>	7
11 Your child can pass something small from one hand to the other hand. (Passes a cube from hand to hand)	<input type="checkbox"/>	<input type="checkbox"/>	7.5
12 Your child can pick up a raisin by bringing together any part of the thumb and any one finger. (Finger-Thumb Grasp)	<input type="checkbox"/>	<input type="checkbox"/>	10
13 When your child is holding a block in each hand, he is able to hit them together, without his hands or arms being touched by you. (Bangs 2 cubes held in hands)	<input type="checkbox"/>	<input type="checkbox"/>	10.5

SCREENING AT 12 MONTHS (6 months - 12 months)

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) <small>Please tick "Yes"/"No"</small> ALL FIELDS SHOULD BE COMPLETED	YES	NO	Age (mths) when 90% achieve the milestone
14 Your child can pick up a small object like a raisin, using only the ends of his thumbs and index finger. (Pincer grasp)	<input type="checkbox"/>	<input type="checkbox"/>	13.5
Language			
15 Your child laughs out loud without being tickled. (Laughs)	<input type="checkbox"/>	<input type="checkbox"/>	4.5
16 You child turns towards the side of the sound of a rattle placed out of sight about 20cm behind each ear. (Responds to sounds)*	<input type="checkbox"/>	<input type="checkbox"/>	7.5
17 Your child makes single sounds consisting of a consonant and a vowel, like "ba", "da", "ga", "ma". (Says single syllables)	<input type="checkbox"/>	<input type="checkbox"/>	10
18 Your child imitates any sound after you e.g. sounds like coughing, clicking of the tongue or any other speech sounds. (Imitates speech sounds)	<input type="checkbox"/>	<input type="checkbox"/>	10
19 Your child uses the word "Papa" and "Mama" specifically. (Says Papa/Mama specifically)	<input type="checkbox"/>	<input type="checkbox"/>	14.5
Gross Motor			
20 When in a sitting position, your child can hold his head upright steadily. (Sits, head steady)	<input type="checkbox"/>	<input type="checkbox"/>	5
21 Your child is able to roll over from stomach to back or back to stomach. (Rolls over)	<input type="checkbox"/>	<input type="checkbox"/>	5
22 When you are holding your child under his arms loosely, he is able to bear some weight on his legs for a few seconds. (Bears weight on legs)	<input type="checkbox"/>	<input type="checkbox"/>	6
23 When your child is placed on his stomach, he can lift his head and chest up using the support of outstretched arms, so that his face is looking straight ahead and the chest is well lifted away from the surface. (Holds chest up, arm support)	<input type="checkbox"/>	<input type="checkbox"/>	7
24 Without being propped by pillows, a chair or a wall, your child is able to sit alone for more than 5 seconds. He can put his hands on his legs or on a flat surface for support. (Sits, no external support)	<input type="checkbox"/>	<input type="checkbox"/>	7.5
25 Your child can stand holding on to a chair or table for more than 5 seconds. (Stands holding on)	<input type="checkbox"/>	<input type="checkbox"/>	9
26 Your child can pull himself to a standing position by himself without help. (Pulls to stand)	<input type="checkbox"/>	<input type="checkbox"/>	10

*The instruction from the Denver Developmental Screening Test (Singapore) has been amended.

Comments of Doctor/Nurse on Developmental Checklist completed by parents:

SCREENING AT 12 MONTHS

(6 months - 12 months)

GROWTH

Weight: _____ kg _____ % Occipito-Frontal Circumference: _____ cm _____ %
Length: _____ cm _____ %

OTHER SCREENING

Remarks (if any): _____

PHYSICAL EXAMINATION (IF DEEMED NECESSARY)

Eye Examination: Fixation on moving object: Right eye Left eye
Cornea/Lens Pupillary Light reflex
Red Reflex Nystagmus: Yes No
Squint: Yes No
Roving Eye Movement: Yes No

Eye Movements _____

<input type="checkbox"/> Fontanelles	<input type="checkbox"/> Heart	<input type="checkbox"/> Femoral pulses	<input type="checkbox"/> Posture
<input type="checkbox"/> Ears	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitals	<input type="checkbox"/> Muscle tone
<input type="checkbox"/> Teeth	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Hips	<input type="checkbox"/> Skin

OUTCOME OF EXAMINATION

Normal Next routine check at: _____
 Needs Follow Up At The Clinic Review: _____
 Needs Further Evaluation Referred to: _____

Remarks (if any): _____

Doctor / Nurse: _____ Signature: _____

Clinic: _____ Date: _____

ORAL HEALTH CHECKLIST (TO BE COMPLETED BY PARENTS AT BIRTH, AGES 6 MONTHS, 1, 2 & 3 YEARS)

Tooth decay can cause a lot of pain and discomfort to your child. Good oral hygiene habits can prevent and reduce tooth decay.

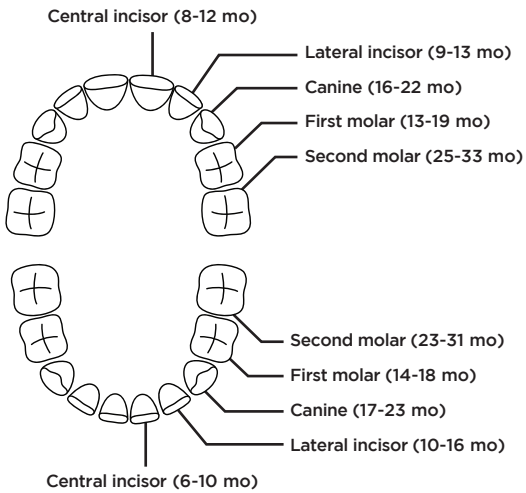
**Please answer the following and tick “YES” / “NO”.
ALL FIELDS SHOULD BE COMPLETED.**

	For Parents	
	Yes	No
1. At Birth		
• I clean my child's gums and tongue at least twice a day with a clean, moist cloth wrapped around my index finger.	<input type="checkbox"/>	<input type="checkbox"/>
2. From approximately 6 months (when the first tooth emerges)		
• I brush my child's teeth at least twice a day (once in the morning and once before bed) using a soft bristled children's toothbrush.	<input type="checkbox"/>	<input type="checkbox"/>
• I fill my child's milk bottle with only milk/water and not any other sweetened drinks (e.g. juices, honey, or soft drinks).	<input type="checkbox"/>	<input type="checkbox"/>
3. From Ages 1 & 2		
• I floss and brush my child's teeth at least twice a day (once in the morning and once before bed, after last milk feed)*.	<input type="checkbox"/>	<input type="checkbox"/>
• I have attempted to wean my child off the milk bottle and switch to a cup.	<input type="checkbox"/>	<input type="checkbox"/>
• I limit the amount and frequency of sweetened beverages and foods my child consumes.	<input type="checkbox"/>	<input type="checkbox"/>
• I do not allow my child to fall asleep with a milk bottle containing formula milk or sugary drinks as that can cause tooth decay.	<input type="checkbox"/>	<input type="checkbox"/>
• When my child wakes up at night for milk, I either give water, dilute the milk in a milk bottle or try other means to soothe my child back to sleep. Frequent or prolonged exposure to sugary drinks (e.g. formula milk) will lead to dental decay.	<input type="checkbox"/>	<input type="checkbox"/>
• I regularly lift my child's upper lip to check for white or brown spots on his/her teeth, which may indicate dental decay.	<input type="checkbox"/>	<input type="checkbox"/>
• When I see possible signs of decay, I make an appointment with a dentist immediately.	<input type="checkbox"/>	<input type="checkbox"/>
• I have brought my child for his/her first dental check by age 1.	<input type="checkbox"/>	<input type="checkbox"/>
4. From Age 3		
• I floss and brush my child's teeth with a pea-sized amount of toothpaste with at least 1000ppm fluoride (F) twice a day. I ensure that my child does not swallow the toothpaste.	<input type="checkbox"/>	<input type="checkbox"/>
• I ensure that my child limits sugar intake.	<input type="checkbox"/>	<input type="checkbox"/>
• I bring my child for regular dental check-ups.	<input type="checkbox"/>	<input type="checkbox"/>

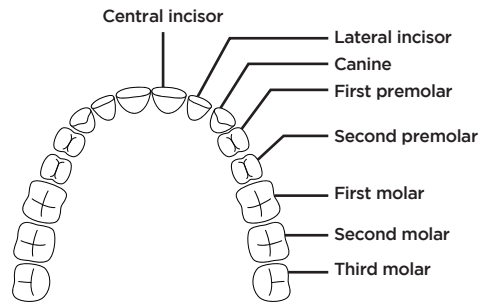
* Due to the concern for dental fluorosis, the recommendation for use of a smear amount (size of a rice grain) of 1000ppm fluoride (F) toothpaste for children < 3 years old should be limited to those at high-risk for dental caries. At the first dental visit, the dentist can determine the caries risk and make the appropriate recommendation for toothpaste use.

EXPECTED AGE OF TOOTH ERUPTION

Baby Teeth



Adult Teeth



	TOOTH	EXPECTED AGE OF TOOTH ERUPTION (years)
ADULT TEETH	Lower Central Incisor	6-7
	Upper Central Incisor	7-8
	Lower Lateral Incisor	
	Upper Lateral Incisor	8-9
	Lower Canine	9-10
	Upper Canine	11-12
	First Premolar	10-12
	Second Premolar	
	First Molar	6-7
	Second Molar	11-13
	Third Molar	17-21

National Childhood Immunisation Schedule (NCIS) (from birth to age 17 years, effective from 1 November 2020)

Vaccine	Birth	2 months	4 months	6 months	12 months	15 months	18 months	2-4 years	5-9 years	10-11 years	12-13 years	13-14 years	15-17 years
Bacillus Calmette-Guérin (BCG)	D1												
Hepatitis B (HepB)	D1	D2		D3									
Diphtheria, tetanus and acellular pertussis (paediatric) (DTaP)		D1	D2	D3			B1						
Tetanus, reduced diphtheria and acellular pertussis (Tdap)										B2			
Inactivated poliovirus (IPV)		D1	D2	D3			B1			B2			
<i>Haemophilus influenzae</i> type b (Hib)		D1	D2	D3			B1						
Pneumococcal conjugate (PCV10 or PCV13)			D1	D2	B1								
Pneumococcal polysaccharide (PPSV23)													
Measles, mumps and rubella (MMR)					D1	D2							
Varicella (VAR)					D1	D2							
Human papillomavirus (HPV2 or HPV4)					D1						D1 (Females)	D2 (Females)	
Influenza (INF)													

One or two doses for children and adolescents age 2-17 years with specific medical condition or indication.

Annual vaccination or per season for all children age 6 months to <5 years (6-59 months).

Annual vaccination or per season for children and adolescents age 5-17 years with specific medical condition or indication

Recommended ages and doses for all children

Recommended for persons with specific medical condition or indication

FOOTNOTES:

- **D1, D2, D3:** Dose 1, Dose 2, Dose 3
- **B1, B2:** Booster 1, Booster 2
- **10-11, 12-13, 13-14 years:** Primary 5, Secondary 1, Secondary 2 (Tdap, IPV, HPV (for females) and MMR (as catch-up) vaccines are provided as part of Health Promotion Board's school-based vaccination programme)
- **HepB:** Doses 2 and 3 are recommended to be given as part of the 6-in-1 vaccine at 2 and 6 months, respectively
- **MMR:** Only the dose 2 is recommended to be given as part of the MMRV vaccine

Immunisations for diphtheria and measles are **COMPULSORY** by law.

The National Immunisation Registry (NIR) maintains immunisation records for all Singapore residents age 18 years and below. Parents can view their child's immunisation records at the NIR website (<https://www.nir.hpb.gov.sg/>) using SingPass for authentication.

The National Childhood Immunisation Schedule has been developed by the Ministry of Health in consultation with the Expert Committee on Immunisation, which comprises specialists from disciplines including infectious diseases, microbiology, paediatrics and public health as well as representatives from both the public and private healthcare institutions.

There are other vaccines that are not part of the National Childhood Immunisation Schedule. Please make an enquiry with your family doctor, polyclinic or specialist for more information on these vaccines.

For more information and updates on immunisation, please visit <https://www.nir.hpb.gov.sg/>.

Immunisation Record of Vaccinations in the National Childhood Immunisation Schedule
 (To be completed by the doctor/nurse giving immunisation, see footnotes below for instruction)

In addition to completing the immunisation record below, medical practitioners are requested to notify the National Immunisation Registry of vaccinations carried out. Notification of vaccination can be done via NIR Doctor Portal (<https://www.nir.hpb.gov.sg/nird/ens/enslogin>).
 Notification of diphtheria and measles vaccinations is mandatory under the Infectious Diseases Act.

Vaccine*	Sequence	Site of Vaccination [†]	Brand of Vaccine [§]	Date Given	Batch No.	Name of Clinic/Stamp of Clinic
Bacillus Calmette-Guérin (BCG)	Dose 1					
	Dose 2					
	Dose 3					
Hepatitis B* (HepB) (e.g. Engerix-B, HBVaxPro)	Dose 1					
	Dose 2					
	Dose 3					
Diphtheria, tetanus, acellular pertussis* (paediatric) (DTaP)	Dose 1					
	Dose 2					
	Dose 3					
Tdap (reduced) (e.g. Adacel, Boostrix)	Booster 1					
	Booster 2					
Inactivated poliovirus* (IPV)	Dose 1					
	Dose 2					
	Dose 3					
	Booster 1					
	Booster 2					
Haemophilus influenzae type b* (Hib)	Dose 1					
	Dose 2					
	Dose 3					
	Booster 1					

Vaccine*	Sequence	Site of Vaccination†	Brand of Vaccine‡	Date Given	Batch No.	Name of Clinic/Stamp of Clinic
Pneumococcal conjugate (PCV10/PCV13) (Synflorix, Prevenar 13)	Dose 1					
	Dose 2					
	Dose 3 (if given)					
	Booster 1					
Measles, mumps, rubella* (MMR) (e.g. M-M-R II, Priorix)	Dose 1					
	Dose 2					
Varicella (chickenpox)* (VAR) (e.g. Varilrix Varivax)	Dose 1					
	Dose 2					
Human papillomavirus (females) (HPV2/HPV4) (Cervarix, Gardasil)	Dose 1					
	Dose 2					
	Dose 3 (if given)					
Influenza (INF) (e.g. Fluorix Tetra, Influvac Tetra, SKYCellflu Quadrivalent, Vaxigrip/tetra)						
polysaccharide pneumococcal (PPSV23) (e.g. Pneumovax 23)*						

CONTRAINDICATIONS/REACTIONS TO VACCINES:

Footnotes:

- * The trade name of commonly available vaccines is listed under the respective generic vaccine names in the "Vaccine" column. For combination vaccines, please refer to the Table below. The trade names are listed as examples and are non-exhaustive.
- † Fill in the anatomical site of vaccine administration under the column "Site of Vaccination" - "left deltoid", "right deltoid", "left anterolateral thigh", "right anterolateral thigh", "left buttock" or "right buttock".
- ‡ Record the generic abbreviation (e.g. HepB) or the trade name (e.g. Engerix-B, HBvaxPro) for each vaccine under the column "Name of Vaccine".
- § For combination vaccines, fill in the generic abbreviation or the trade name and other details in the appropriate rows. E.g. for MMRV, fill in the abbreviation/trade name in both "MMR" and "varicella" rows. Refer to the table below for commonly available combination vaccines.
- ** PPSV23 is recommended only for persons with specific medical condition or indication.

TABLE: COMMONLY AVAILABLE COMBINATION VACCINES

Description	Generic Abbreviation	Trade Name
DTaP, inactivated poliovirus, and <i>Haemophilus influenzae</i> type b vaccine	DTaP-IPV-Hib	Infanrix-IPV+Hib Pentaxim
DTaP, inactivated poliovirus, <i>Haemophilus influenzae</i> type b and hepatitis B vaccine	DTaP-IPV-Hib-HepB	Hexaxim Infanrix hexa
Tdap and inactivated poliovirus vaccine	Tdap-IPV	Adacel-Polio Boostrix Polio
Measles, mumps, rubella and varicella vaccine	MMRV	Priorix-Tetra ProQuad

Immunisation Record of Other Vaccinations

(To be completed by the doctor/nurse giving immunisation, see footnotes below for instruction)

Vaccine*	Sequence	Site of Vaccination†	Name of Vaccine§	Date Given	Batch No.	Name of Clinic/Stamp of Clinic
Rotavirus (e.g. Rotarix, Rotateq)		Oral				
		Oral				
		Oral				
Hepatitis A² (e.g. Avaxim, Havrix, Vaxta)						
Meningococcal (e.g. Menactra, Menveo, Nimenrix)						
Others (Specify)						

CONTRAINDICATIONS/REACTIONS TO VACCINES:

Footnote:

- * The trade name of commonly available vaccines is listed under the respective generic vaccine names in the "Vaccine" column. The trade names are listed as examples and are non-exhaustive.
- † Fill in the anatomical site of vaccine administration under the column "Site of Vaccination". - "left deltoid", "right deltoid", "left anterolateral thigh", "right anterolateral thigh", "left buttock" or "right buttock".
- § Record the generic abbreviation (e.g. HepA) or the trade name (e.g. Avaxim, Havrix, Vaxta) for each vaccine under the column "Name of Vaccine". For combination vaccines (if any), fill in the generic abbreviation or the trade name and other details in the appropriate rows.