



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

MEDICAL CERTIFICATION FOR COVID-19 PEDIATRIC VACCINATION
(12-17 YEARS OLD WITH COMORBIDITIES)

Date: _____

TO WHOM IT MAY CONCERN:

This is to certify that _____,
(Name of Patient) *(Age)*

years old, from _____
(Address)

is a diagnosed case of:

- I have thoroughly explained the risks and benefits of COVID-19 vaccination.
- Based on evaluation done on the date of certification, the patient can receive COVID-19 vaccine.
- Parent / Legal Guardian is aware that the vaccine recipient will still be subjected to health screening at the vaccination site, and that If symptoms arise, reevaluation is necessary prior to vaccination.

This Medical Certificate is being issued for the COVID-19 Vaccine Deployment and Vaccination Program of the Philippines.

_____, MD
(Name and Signature)

(PRC No.)