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| **Patient initials / number**:  (*first, middle, last*)  Sex: M  F  Pregnant  Lactating  Date of birth (*day/month/year*): \_ \_ /\_ \_ \_ /\_ \_ \_ \_  OR age group at onset: 0 < 1 year  1- 5 years  > 5years -18 years  >18 years –60 years  >60 years  Date patient notified event to health system  (*day/month/year*): \_ \_ /\_ \_ \_ /\_ \_ \_ \_ | Reporter’s Name: Institution:  Designation &Department:  Region:  Telephone & e-mail:  Today’s date (*day/month/year*): \_ \_ /\_ \_ \_ /\_ \_ \_ \_ |
| Health facility (or vaccination centre) name: | |

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| **Vaccine** | | | | | | | **Diluent** | | |
| **Name of vaccine (Generic)** | **\*Brand Name and Name of Manufacturer** | **\*Date of vaccination**  *day/month/year* | **\*Time of vaccination**  **(**24hrs) | **Dose  (1st, 2nd, etc.)** | **\*Batch/ Lot number** | **Expiry date** | **\*Batch/ Lot number** | **Expiry date** | **Time of reconstitution**  (24hrs) |
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| **Adverse event(s):**  Severe local reaction  *>3 days*  beyond nearest joint  Seizures  febrile  afebrile  Abscess  Sepsis  Encephalopathy  Toxic shock syndrome  Thrombocytopenia  Anaphylaxis  Fever≥38°C  Other (specify)  Date (*day/month/year*) & Time (24 Hr/Min) AEFI started**:**  \_ \_ /\_ \_ \_ /\_ \_ \_ \_ \_ \_ /\_ \_ | Describe AEFI (Signs and symptoms): | |
| **Serious: Yes** **No**  If Yes: Death\*  Life threatening  Disability  Hospitalisation  Congenital anomaly  Important medical event  or Other  (Specify)  **Outcome:** Recovering  Recovered  Recovered with sequelae  Not Recovered  Unknown  \*Date of death (*day/month/year*): \_ \_ /\_ \_ \_ /\_ \_ \_ \_ Autopsy done: Yes No  Unknown  If yes, provide report | | |
| Provide past medical history (including history of similar reaction or other allergies), concomitant medication and dates of administration (exclude those used to treat reaction) other relevant information (e.g. other cases)***.*** Use additional sheet if needed**:** | | |
| Date report received by MCA (*day/month/year*): \_ \_ /\_ \_ \_ /\_ \_ \_ \_ | | MCA AEFI number: |
| Comments: | | |