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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: |