Ministry of Health and Social Services

ADVERSE EVENT FOLLOWING IMMUNIZATION REPORTING FORM

Patient Identification	Birth Date	Age _____Yrs	Sex ☐ Male ☐ Female ☐ Unknown	Date of Vaccination

Vaccine

Vaccine Name Given	Dose Number	Site	Route	Dosage	Manufacture	Batch Number
	☐ 1st ☐ 2nd ☐ 3rd					

Suspected Adverse Events

☐ Malaise	☐ Severe Vomiting and Diarrhea	☐ Convulsion
☐ Severe local reaction	☐ Rash Itching	☐ Neuropathy
☐ Injection site abscess	☐ Urticaria	☐ Encephalopathy
☐ Screaming / Persistent crying	☐ Severe skin reaction: Stevens Johnson, Epidermal necrolysis	☐ Guillain-Barre Syndrome
☐ Fever within 48 hrs _____0C(or_____0F)	☐ Angioedema	☐ Paresis
☐ Lymphadenopathy ☐ Collapse or shock like state within 48 hrs	☐ Larynx oedema	Other unusual event, please specify
☐ Arthralgia/ Myalgia	☐ Bronchospasm	
☐ Arthritis, joint swelling	☐ Dyspnoea	
	☐ Diabetes	

Seriousness: ☐ death ☐ hospitalization ☐ congenital-anomaly ☐ life-threatening ☐ disabling ☐ other medically important condition

Outcome of event at the time of the report: ☐ Fully recovered ☐ Recovered with sequelae ☐ Fatal- unrelated to reaction ☐ fatal - reaction may be contributory ☐ fatal - due to reaction ☐ unknown

*Medication used other than medicine used to treat the Adverse event	*Relevant Medical History: including pre-existing medical conditions (allergies, pregnancy, alcohol use, liver problem)

Reported by (Name)	Name of Health Facility	District/Directorate
Profession	Date of report	Tel. Number
	(DD/ MM/ YY)	