MINISTRY OF HEALTH AND SOCIAL SERVICES

ADVERSE EVENT FOLLOWING IMMUNIZATION (AEFI) REPORTING FORM

Submit the completed form to the following email address: AEFI@mhss.gov.na

Email Subject: AEFI Minor/Serious: Name of District

Name of vaccination site is attached to: Name of site where Vaccine is administered (Location):	Outreach / Mobile /Fixed District: Region:	Date of vaccination: (DD/MM/YY) Time of vaccination: (Hour/ Minute) Date AEFI reported: (DD/MM/YY) Time AEFI Reported: (Hour/Minute) Reporter's full name: Reporter's contact number:
Patient First and Last name: Identity no: Nationality:	Next of Kin details First Name and last Name: Contact Nr.	
Unique ID	Patient's Contact Number: Physical Address of Patient:	

Birth Date: (DD / MM / YYYY), if unknown, enter the age Age _____ Months_____ Years _____	Patient Gender: Sex: Male □ Female □

Vaccine						Diluent				
Name of vaccine	Manufacturer	Batch/ Lot number	Expiry date	Dose (1st , 2nd , 3rd, additional	Dosage	Route	Injection Site	Batch/ Lot number	Expiry date	Time of Reconstitution

Minor or Serious Adverse Event Documentation

□	Severe local reaction	□	>3 days
□	**Seizures**	□ Febrile	□ afebrile
□	Abscess	□	Toxic shock syndrome
□	Sepsis	□	Anaphylaxis
□	Encephalopathy	□	Fever≥38°C
□	Collapse or shock like state within 48 hours	□	Convulsion
□	Thrombocytopenia	□	Other

Date AEFI Started:

Time AEFI started:

Describe AEFI (Signs and symptoms) here:

Action taken: Onsite

Vaccine reaction: Minor or Severe Adverse Event

□ **Minor***(if minor, enter into DHIS2 Tracker/send the form to National level)*	_____ □ Other medically important event (Specify) below:
□ **Severe** *(indicate and complete the form)* □ Hospitalization □ Life-threatening □ Disabling □ Congenital Anomaly □ Death – Date: __ __ / __ __ / __ __ __ __ Autopsy done: □ Yes □ No □ Unknown	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:

Outcome of event at the time of the report:

□ Fully recovered	□ Recovered with sequelae	□ Unknown
District level to complete	Investigation needed? □ Yes □ No □ Not done If yes, date investigation planned: If not done: Reason:	If done: Date completed: Date reports submitted electronic to Regional level: Date reports submitted electronic to National level: Date entered into DHIS 2 Tracker:
National level to complete	Date report received at national level	Comments