AEFI Reporting ID Number:

REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)

***Patient name:** ***Patient's full Address:** **Telephone:** **Sex:** ☐M ☐ F ***Date of birth (DD/MM/YYYY):** ☐☐ / ☐☐ / ☐☐☐☐ *OR Age Group:* ☐*< 1 Year* ☐ *1 to 5 Years* ☐ *> 5 Years*	***Reporter's Name:** **Institution / Designation, Department & address:** **Telephone & e-mail:** **Date:** **Signature:**

Name of health facility (or vaccination centre):

*Name of Vaccines Received	*Date of vaccination	*Time of vaccination	Dose (e. g. 1st, 2nd, etc.)	*Batch/ Lot number	Expiry date

***Adverse event (s):**

- ☐ Local reaction ☐ *>3 days* ☐ *beyond nearest joint*
- ☐ Fever≥38° C
- ☐ Seizures ☐ *febrile* ☐ *afebrile*
- ☐ Abscess
- ☐ Sepsis
- ☐ Toxic shock syndrome
- ☐ Thrombocytopenia
- ☐ Anaphylaxis
- ☐ Other (specify)................................

Date & Time AEFI started (DD/MM/YYYY): ☐☐ / ☐☐ / ☐☐☐☐ . ☐☐ Hr ☐☐Min

Was the patient hospitalized? ☐Yes ☐No

Date event was notified to health system (DD/MM/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

Describe AEFI (Signs and symptoms):

***Outcome:**

☐ Recovering ☐ Recovered ☐ Recovered with sequelae ☐ Not Recovered ☐ Unknown

☐ Died If died, date of death (DD/MM/YYYY): ☐☐ / ☐☐ / ☐☐☐☐ Autopsy done: ☐Yes ☐No ☐Unknown

Past medical history (including history of similar reaction or other allergies), concomitant medication and other relevant information (e.g. other cases). *Use additional sheet if needed :*

First Decision making level to complete:

Investigation needed: ☐ Yes ☐ No If yes, date investigation planned (DD/MM/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

National level to complete:

Date report received at national level (DD/MM/YYYY): ☐☐ / ☐☐ / ☐☐☐☐	AEFI worldwide unique ID **:**
Comments:	

**Compulsory field*