

Appendix 44. Individual notification form for AEFI with measles vaccine

Province: _____ Patient's last name: _____
District: _____ Patient's first name: _____
Health facility/site: _____ Address and contact (tel, mail): _____
If hospital, indicate the unit/ward: _____
Name of notifying person: _____
Date of notification: _____ Age (months/years): _____

Information on immunisation

Vaccination card: Yes No (*if no, indicate the source of information*):

Place vaccine administered (village, vaccination site):

Date vaccine administered:

Route of administration: SC IM

Injection site: Arm Thigh Other (*specify*):

	Manufacturer	Batch number	Expiry date
Vaccine			
Diluent			

Total number of vaccinated children (same day, same place):

Adverse events following immunization

Date onset of adverse event:

History of allergy: No Yes (*specify*):

Time interval between vaccine administration and onset of reaction:

Type of reaction (*specify*):

- Fever: No Yes (*specify T°*):
 - Skin eruption: No Yes (*indicate location*):
 - Local reaction at injection site: No Yes (*specify: pain, redness, infection, other*):
 - Swelling, oedema: No Yes (*indicate location*):
 - Other (*specify: anaphylactic reaction, neurologic events, etc.*):
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Management and outcome

Treatment received (*drugs and doses*):

Hospitalised: No Yes (*indicate duration*):

- Outcome: Fully recovered
 Sequelae (*specify*):
 Death (*specify date and cause*):
 Unknown (lost to follow-up)
 Other (*specify*):