### 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)*

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Manufacturer</th>
<th>Batch number</th>
<th>Expiry date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diluent</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **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.)*: ______________

#### 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)*: ______________