# 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 at onset:**

- [ ] ___ Years
- [ ] ___ Months
- [ ] ___ Days

OR **Age Group:**

- [ ] < 1 Year
- [ ] 1 to 5 Years
- [ ] > 5 Years

**Reporter’s Name:**

Institution / Designation, Department & address:

**Telephone & e-mail:**

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## Health facility (or vaccination centre) name:

<table>
<thead>
<tr>
<th>*Name of Vaccines Received</th>
<th>*Date of vaccination</th>
<th>*Time of vaccination</th>
<th>Dose (e.g. 1st, 2nd, etc.)</th>
<th>*Batch/ Lot number</th>
<th>Expiry date</th>
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## *Adverse event(s):*

- [ ] Severe local reaction
- [ ] > 3 days
- [ ] beyond nearest joint
- [ ] Seizures
- [ ] Febrile
- [ ] Afebrile
- [ ] Abscess
- [ ] Sepsis
- [ ] Encephalopathy
- [ ] Toxic shock syndrome
- [ ] Thrombocytopenia
- [ ] Anaphylaxis
- [ ] Fever ≥38°C
- [ ] Other (specify) ........................................

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

Was the patient hospitalized?  
- [ ] Yes  
- [ ] No

Date patient notified event to health system (DD/MM/YYYY): ___ ___ / ___ ___ / ___ ___ ___

## *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:

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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:

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*Compulsory field*