MINISTRY OF HEALTH & WELLNESS

**ESAVI reporting ID number:**

# MINISTRY OF HEALTH AND WELLNESS

## REPORTING FORM FOR EVENTS SUPPOSEDLY ATTRIBUTED TO VACCINATION OR IMMUNIZATION (ESAVI)

***Patient Name*:** _____

***Patient's full Address*:** _____

_____

Telephone: _____

Sex: ☐ M ☐ F Currently pregnant: ☐ Yes ☐ No

***Date of birth (DD/MM/YYYY)*:** _ _ _ _ _ _ _ _ _ _

*OR Age at onset:* _____*Years* _____*Months* _____ *Days*

***Reporter's Name*:** _____

Institution: _____

Post & Department: _____

Address: _____

_____

Telephone & E-mail: _____

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

**Today's date *(DD/MM/YYYY)*:** _ _ _ _ _ _ _ _ _ _

**Health Facility (place or vaccination centre) name & address:**

| ***Vaccine*** | | | | | | ***Diluent (if applicable)*** | | | |
|---|---|---|---|---|---|---|---|---|---|
| ***Name of vaccine*** | ***Date of vaccination*** | ***Time of vaccination*** | Dose (1st, 2nd, etc.) | ***Batch /Lot number*** | Expiry date | Name of diluent | ***Batch /Lot number*** | Expiry date | Date and time of reconstitution |
| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

***Adverse event(s):***

☐ Local reaction ☐ *>3 days* ☐ *beyond nearest joint*
☐ *pain* ☐ *redness* ☐ *swelling*
☐ Seizures
☐ *febrile* ☐ *afebrile*
☐ Headache
☐ Fever ≥ 38ºC
☐ Abscess
☐ Myalgia
☐ Sepsis
☐ Encephalopathy
☐ Thrombocytopenia
☐ Anaphylaxis

Other *(specify)*

☐ .....
☐ .....
☐ .....

**Date ESAVI started *(DD/MM/YYYY)*:** _ _ _ _ _ _ _ **Time** _ _:_ _

Describe ESAVI (Signs & Symptoms) and Treatment (*if any*):

***Serious:*** ☐ ***Yes*** ☐ ***No;*** ➔ If Yes ☐ Death ☐ Life threatening ☐ Persistent or significant disability ☐ Hospitalization ☐ Congenital anomaly

☐ Other important medical event (specify).....

***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 sheets if needed:*

***Parish level to complete:***

| Investigation needed: ☐ Yes ☐ No | If Yes, date investigation planned *(DD/MM/YYYY)*: _ _ _ _ _ _ _ _ |
|---|---|

***Reviewed and signed off by MO(H):*** _____ *Date (DD/MM/YYYY):*_ _ _ _ _ _

*Name and Signature*

***National level to complete***

| Date report received at National level (*DD/MM/YYYY)*: _ _ _ _ _ _ _ _ | ESAVI worldwide unique ID **:** |
|---|---|
| Comments: | |

**** Compulsory field***