Vaccine Preventable Disease Program
Department of Public Health
Ministry of Health

ADVERSE EVENT FOLLOWING IMMUNIZATION (AEFI) Reporting Forms

Patient Information: **Name:**			**Date of birth:**		**Sex:**	
Name & Address of the Parent/G uardian :					Mobile No:	
Information on the vaccine						
Name of Vaccine Received	Date of vaccination	Time of vaccination	Dose (1^{st}, 2^{nd} , 3^{rd}, 4^{th})	Batch/Lot Number	Expiry date	VVM Status (I, II, III, IV)
Diluent Used: □ No □ if 'yes', Diluent batch lot number			Expiry date of Diluent :			
Place of vaccination: Hosp. □ PHC □ ORC □						Date

Adverse Events: Date of AEFI reported: ----------	**Time of AEFI started: ----------**
Local Adverse Events Requiring investigation	Injection site abscess □ BCG Lymphadenitis □ Severe local reaction □
CNS Adverse Events	Vaccine associated paralytic poliomyelitis □ GBS □ Encephalopathy □ Encephalitis □ Meningitis □
Requiring investigation	Seizures Febrile □ Seizures Afebrile □ Sepsis □
Other Adverse Events	Anaphylaxi □ Persistent screaming □ Osteitis / Osteomyelitis □
Requiring investigation	Hypotonic Hyporesponsive Episode □ Toxic Shock Syndrome □
Adverse Events Not Requiring investigation **Yes No**	Allergic reaction □ Arthralgia □ High fever (>39°C / 102°F) □ Nodule at the injection site □
Other Adverse Events : Please write here:	
Date & Time referring to higher center	
Medical History/other	**Outcome:**
	Hospitalized: Yes /No if 'Yes', Hospital Registration No: ---------- Still in the hospital □ Discharged □
	Outcome Recovered completely □ Partially recovered □ Death □
Reporting source:	
Date of the notification: Name & Signature of the notifying officer: Mobile No:	Name of Health Centers: