

Patient's Information: Date Patient's Address Patient's Pati				ADVERSE	EVENT	FC	LLOWIN	G IMMUNI	ZATION	FORM	Λ		
Date of Birth: Age: (Years) or(Months) Contact Number Conta	Patient's	Information	า:						Dat	e:			
Gender Meight Height (cm) Weight (kg) Contact Number												:	
Marrier Meight	Date of Birth: Age: _						(Years) or (Months)						
Severe Coatrescion	Gender:		Hoigh	ot: (cr	m)	\/\oi	aht:	(Ka)		1			
Sepert Local reaction > 3 days beyond nearest joint Separate Separa	M L F L Other L 5 5 5 5 5 5 5 5 5												
Adverse Contact Cont													
Seizures Gebrile afebrile Abscess Sepais Sepa			ion 🔲 :	> 3 days □ b	eyond								
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Comment Comm													
Trombocytopenia	· ·						iagiiooo,				Moderate	related	
Treatment Details: (any tests or diagnostics performed, attach reports) Treatment Details: (any tests or diagnostics performed, attach reports) Treatment Details: (any tests or diagnostics performed, attach reports) Treatment Details: (any tests or diagnostics performed, attach reports) Treatment Details: (any tests or diagnostics performed, attach reports) Treatment Details: Treatment Deta	1												
General Sain Gene	1								- '-	_/	threatening		
Generic 38°C (Specify)								(HH : MM)	(HH	: MM)	5 = Fatal		
Severe Seriousness of the reaction: No I'Yes (Please tick below anyone) Death (dd/mm/yyyy) Congenital Anomaly Disability Disabilit	☐ Fever	² ≥ 38 ⁰ C (Spec	cify)	ºC				::		_:			
Seriousness of the reaction: No If Yes (Please tick below anyone) Death (dd/mm/yyyy) Congenital Anomaly Life Threatening Disability Disability Hospitalization - Initial/Prolonged Other Medically Important													
□ Death (dd/mm/yyyy) □ Congenital Anomaly □ Life Threatening □ Other Medically Important Death (dd/mm/yyyy) □ Death Deat													
□ Disability □ Hospitalization - Initial/Prolonged □ Other Medically Important Outcome: □ Recovered □ Recovering □ Not Recovered □ Fatal □ Recovered with sequelae □ Unknown Suspected Vaccine Details: Name Brand name Other Date of Time of Oscillation Vaccination	· · · · · · · · · · · · · · · · · · ·												
Dutcome:													
Recovered Recovering Not Recovered Fatal Recovered with sequelae Unknown													
Suspected Vaccine Details: Vaccine Details Vaccine Details Date of incl. Name Date of incl. Name of the incl. Name of the waccine of the waccination Vaccination Vacc													
Name Brand name Inc. Nam													
of the Vaccine the Manufacturer Vaccination Vaccination (1st/2nd/3rd/ 4rh/5rh/ 4rh/5rh/5rh/ 4rh/5rh/ 4rh/5rh/5rh/ 4rh/5rh/													
Vaccine the Manufacturer Ath/5th/ Booster) Booster)		Brand nan	ne [Date of	Time of				Expiry	Batch/l	ot Expiry	Time of	
Manufacturer			e of \	Vaccination	Vaccinat	ion	`	Number	Date	Numbe	r Date	reconstitution	
Relevant Medical History: Any other vaccination received within 4 weeks of the suspected vaccination, illness at the time of vaccination, Allergies, Birth defects, Birth weight, Medical condition, History of adverse evets following immunization, Vaccination in the patientor sibling set: Treatment Details: (any tests or diagnostics performed, attach reports)	Vaccine		ıror										
Treatment Details: (any tests or diagnostics performed, attach reports) Action taken after event: Discontinued the next dose Continued the next dose Not Applicable Concomitant Vaccines, Medical Product including self-medication and herbal remedies with therapy dates (Exclude those used to treat reaction) S. Name (Brand/Generic) No. (Brand/Generic) Reporter's Details: Name:		iviariulactu	1161				Doostel)						
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