

COVID-19 VACCINATION FORM

VACCINATION SITE UID NUMBER																				
VACCINATION SITE NAME																				
VACCINEE INFORMATION	<i>(All personal particulars such as names, surname, date of birth, occupation, etc. should be official particulars that appear in your ID or Passport, medical aid card, municipality bill, etc.)</i>																			
Identity number/ Passport number																				
First name(s)																				
Surname																				
Date of birth	Y	Y	Y	Y	M	M	D	D												
Sex	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>																
Email address																				
Cellphone number																				
Alternative cellphone number																				
Preferred language																				
Are you a member of a medical aid scheme?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	<i>(If yes, please provide medical aid details below)</i>															
Medical aid scheme																				
Medical aid number																				
Are you employed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	<i>(If yes, please provide employment details below)</i>															
Job Title																				
Name of primary employer																				
Full name of the institution where employed																				
Village/Town/City																Province				
Health professional	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>																
Sector	Public	<input type="checkbox"/>	Private	<input type="checkbox"/>	NGO	<input type="checkbox"/>														
Professional Registration Number																				

PRE- IMMUNISATION QUESTIONS		<i>(To be completed by the vaccinator)</i>																	
Do you have any chronic conditions?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>															
<i>(If yes, please select relevant condition)</i>	TB	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Cardiac Disease	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Other, specify				

Have you been diagnosed with a COVID-19 infection in the last 90 days?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If yes, when did you test positive?	Y	Y	Y	Y	M	M	D	D							
Have you received any vaccinations in the past two weeks? <i>If yes, please indicate what vaccines were received</i>					Yes	<input type="checkbox"/>	No	<input type="checkbox"/>												
Vaccine name/s																				
Have you had any COVID-19 vaccine at any time? <i>If yes, what and when did you receive it?</i>					Yes	<input type="checkbox"/>	No	<input type="checkbox"/>												
Vaccine name																				
Date of vaccination	Y	Y	Y	Y	M	M	D	D												
Name of clinic /Vaccination site where vaccine was received																				

ALLERGIES		<i>(History of allergies not a contraindication but should be reviewed with the vaccinator)</i>																				
Do you have a history of severe symptoms after receiving another vaccination or an injectable medication (a shot given intravenously, intramuscularly, or subcutaneously)? <i>If yes, please describe the symptoms:</i>																			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have a history of an anaphylactic reaction to anything other than a vaccine or injectable medication? <i>If yes, please describe the reaction from the symptom list below:</i>																			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Trouble breathing																			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Broke out in hives																			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Facial or tongue swelling																			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Low blood pressure																			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>



PREGNANCY <i>(Female vaccinee recipients only)</i>	
Do you suspect that you might be pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>(Pregnancy might be a contra-indication and should be discussed with the vaccinator and recorded on EVDS)</i>	

INFORMED CONSENT FORM <i>(To be read to the vaccinee by the vaccinator)</i>	
<p>The COVID-19 vaccination will reduce the chance of you suffering from COVID-19 disease. Like all medicines, no vaccine is completely effective and it takes a few weeks for your body to build up protection from the vaccine. Some people may still get COVID-19 despite having a vaccination, but this should lessen the severity of any infection.</p> <p>The vaccine cannot give you COVID-19 infection, and you have to complete the vaccination schedule for this vaccine to reduce your chance of becoming seriously ill. You will still need to follow the guidance in your workplace and public areas, including wearing the correct personal protection equipment and taking part in any screening programmes. Like all medicines, vaccines can cause side effects. Most of these are mild and short-term, and not everyone gets them. This vaccine has been authorised for use by the South African Health Products Regulatory Authority, in terms of the Medicines and Related Substances Act (Act 101 of 1965) for the active immunisation of individuals ≥18 years old for the prevention of coronavirus disease 2019 (COVID-19).</p>	
Name of vaccine	
Type of authorisation	<input type="checkbox"/> 1. Full registration <input type="checkbox"/> 2. Section 21 approval <input type="checkbox"/> 3. Study approval
<p>1. I understand that the majority of adverse reactions are mild to moderate in severity and usually resolve within a few days of vaccination; and these expected side effects have been described.</p> <p>2. I confirm that I have been fully informed and all my questions answered.</p> <p>3. I have also been informed that:</p> <p>3.1 the quality, effectiveness, and safety of this vaccine have been verified by the South African Health Products Regulatory Authority (SAHPRA).</p> <p>3.2 appropriate measures will be taken to prevent, monitor, and manage the unwanted effects on me of this vaccine.</p>	

CONSENT TO RECEIVE COVID-19 VACCINATION <i>(Please select one option)</i>	
I agree to receive the COVID-19 vaccination as explained to me Yes <input type="checkbox"/> No <input type="checkbox"/>	
Surname	Names
Signature	DATE: Y Y Y Y M M D D

VACCINE INFORMATION										
Vaccine Name	Vaccine manufacturer	Vaccine batch number	Vaccine expiry date							
			Y	Y	Y	Y	M	M	D	D

VACCINE DOSE <i>(Circle the relevant dose and record the date)</i>	
1 st Dose / 2 nd Dose / 3 rd Dose	Y Y Y Y M M D D

ADVERSE EVENTS FOLLOWING IMMUNISATION <i>(Vaccinee to be observed immediately after vaccination for any possible adverse events; if any adverse event is observed, it must be recorded in the AEFI System)</i>	
Did any adverse event occur? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, was it recorded in the AEFI system? Yes <input type="checkbox"/> No <input type="checkbox"/>	

VACCINATOR INFORMATION									
Surname					Names				
Identity number									
Job title					Facility of employment				
Professional body			HPCSA / SANC <i>(circle relevant body)</i>			Professional registration number			
Cellphone number									
Signature					DATE: Y Y Y Y M M D D				

