

COVID-19 VACCINATION FORM



VACCINATION SITE UID NUMBER																
VACCINATION SITE NAME			3.00					***	9 1	1902			*	934)		
	ersonal part rd, municip		uch as names, etc.)	surname	e, date of b	irth, occup	pation, e	etc. shoul	d be official _l	particulars	that appeal	r in your ID	or Passpor	t, medical		
Identity number/ Passport number																
First name(s)					•	'							•			
Surname						,										
Date of birth	γ	Υ	Υ	γ	M	P	VI	D	D							
Sex	Male		Fema	le												
Email address				-200		1237										
Cellphone number																
Alternative cellphone number																
Preferred language							11.9-2									
Are you a member of a medical aid scheme?	Yes		No						(If yes, pleas	se provide i	medical aid	details be	low)			
Medical aid scheme																
Medical aid number																
Are you employed?	Yes		No					(If yes, please	e provide e	mployment	details bei	ow)			
Job Title																
Name of primary employer																
Full name of the institution where employed																
Village/Town/City	Province															
Health professional	Yes		No		2			·								
Sector	Public		Priva	te 🔃		NG0										
Professional Registration Number																
PRE- IMMUNISATION QUESTIO	NS	(To be d	completed by t	he vacci	nator)											
Do you have any chronic conditions?	Yes		No 📗													
	ТВ Нуре				on 🗌	Dial	betes		Cardiac	Disease						
(If yes, please select relevant condition)	HIV/AIDS Lung Disease Cancer Other, specify															
Have you been diagnosed with a COVID-19 infection in the last 90 days?	Yes No			If yes, when did you test positive?								M	D	D		
Have you received any vaccinations in the past two weeks? If yes, please indicate what vaccines were received			Yes No													
Vaccine name/s																
Have you had any COVID-19 vaccine at any time? If yes, what and when did you receive it?				Yes No												
Vaccine name																
Date of vaccination				Y Y Y M M D D												
Name of clinic /Vaccination site where vaccine was received																
ALLERGIES (History of allergies not a co	ntraindicati	on but st	nould be reviev	wed with	n the vaccir	nator)						195				
Do you have a history of severe symptoms after receiving another vaccination or an injectable medication (a shot given intravenously, intramuscularly, or subcutaneously? If yes, please describe the symptoms:								No								
Do you have a history of an anaphylactic reaction to anything other than a vaccine or injectable medication? If yes, please describe the reaction from the symptom list below: Yes N							No									
Trouble breathing													s	No		
Broke out in hives													s 🔲	No		
Facial or tongue swelling												Ye	s	No 🗌		
Low blood pressure												Ye	s	No \square		

PREGNANCY (Female vaccinee recipients only)									
Do you suspect that you might be pregnant? Yes No (Pregnancy might be a contra-indication and should be discussed with the vaccinator and recorded on EVDS)									
INFORMED CONSENT FORM (To be read to the vaccinee by the vaccinator)									
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.									
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).									
Name of vaccine									
Type of authorisation									
 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. I confirm that I have been fully informed and all my questions answered. I have also been informed that: the quality, effectiveness, and safety of this vaccine have been verified by the South African Health Products Regulatory Authority (SAHPRA). appropriate measures will be taken to prevent, monitor, and manage the unwanted effects on me of this vaccine. 									
CONSENT TO RECEIVE COVID-19 VACCINATION (Please select one option)									
I agree to receive the COVID-19 vaccination as explained to me									
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									
VACCINE DOSE (Circle the relevant dose and record the date)									
1st Dose / 2nd Dose / 3nd Dose Y Y Y Y M M D D									
ADVERSE EVENTS FOLLOWING IMMUNISATION (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) Did any adverse event occur? Yes No									
If yes, was it recorded in the AEFI system? Yes No									
VACCINATOR INFORMATION									
Surname Names									
Identity number									
Job title Facility of employment									
Professional body HPCSA / SANC (circle relevant body) Professional registration number									
Cellphone number									
Signature DATE: Y Y Y Y M M D D									