

PREGNANCY (Female vaccinee recipients only)	
Do you suspect that you might be pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
(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)	
<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
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. 2. I confirm that I have been fully informed and all my questions answered. 3. I have also been informed that: 3.1 the quality, effectiveness, and safety of this vaccine have been verified by the South African Health Products Regulatory Authority (SAHPRA). 3.2 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 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		

VACCINE DOSE (Circle the relevant dose and record the date)	
1 st Dose / 2 nd Dose / 3 rd 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 <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 (circle relevant body)			Professional registration number				
Cellphone number									

Signature	DATE: Y Y Y Y M M D D
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