To be completed by nurses and return to the District Medical Officer.

PATIENT INFORMATION

Name: ____________________________

Sex: M: [ ] F: [ ]

Registration number: ________________

Weight: ____________________________

Name of attending physician: ____________________________

Medical History:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

ADVERSE EVENT DETAILS

Tick the relevant box to show which event(s) the child has suffered from and write in the date of the adverse event.

- **Vomiting**: [ ]
  - Date of onset: __________
- **Mild skin reaction**: [ ]
  - Date of onset: __________
- **Tummy pain or Diarrhoea**: [ ]
  - Date of onset: __________
- **Drowsiness**: [ ]
  - Date of onset: __________
- **Fever**: [ ]
  - Date of onset: __________
- **Headache**: [ ]
  - Date of onset: __________

To be completed by the Chief District Medical.

ACTIONS TAKEN

- Treatment: No: [ ] Yes: [ ]
  - Specify: ____________________________
- Follow up: __________
- Hospitalisation: __________
- Follow up: __________
- Other: ____________________________

SMC DETAILS

- Months Number: __________
- Batch No: ____________________________
- Date Given: __________
- Expiry Date: __________