

DRUG ADVERSE EVENTS FORM

Name

Role

Date

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

District Village/ area Health Center

PATIENT INFORMATION

Name:

Date of Birth or Age:

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 <input type="checkbox"/> Date of onset <input type="text"/> <input type="text"/> <input type="text"/>	 Mild skin reaction <input type="checkbox"/> Date of onset <input type="text"/> <input type="text"/> <input type="text"/>	 Tummy pain or Diarrhoea <input type="checkbox"/> Date of onset <input type="text"/> <input type="text"/> <input type="text"/>	Description of event: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
 Drowsiness <input type="checkbox"/> Date of onset <input type="text"/> <input type="text"/> <input type="text"/>	 Fever <input type="checkbox"/> Date of onset <input type="text"/> <input type="text"/> <input type="text"/>	 Headache <input type="checkbox"/> Date of onset <input type="text"/> <input type="text"/> <input type="text"/>	

To be completed by the Chief District Medical.

ACTIONS TAKEN

Treatment: No: Yes: Specify: _____

Follow up: Other: _____

Hospitalisation: _____

Follow up: _____

SMC DETAILS

Date Given: Months Number: 1 2 3 4 Batch No : Expiry Date: