health
Department:
Health
REPUBLIC OF SOUTH AFRICA

COVID-19 VACCINATION FORM

2030 NDP

VACCINATION SITE UID NUMBER	
VACCINATION SITE NAME	

VACCINEE INFORMATION

(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.)

Identity number/ Passport number	
First name(s)	
Surname	
Date of birth	Y Y Y Y M M D D
Sex	Male ☐ Female ☐
Email address	
Cellphone number	
Alternative cellphone number	
Preferred language	
Are you a member of a medical aid scheme?	Yes ☐ No ☐ *(If yes, please provide medical aid details below)*
Medical aid scheme	
Medical aid number	
Are you employed?	Yes ☐ No ☐ *(If yes, please provide employment details below)*
Job Title	
Name of primary employer	
Full name of the institution where employed	
Village/Town/City	Province
Health professional	Yes ☐ No ☐
Sector	Public ☐ Private ☐ NGO ☐
Professional Registration Number	

PRE- IMMUNISATION QUESTIONS

(To be completed by the vaccinator)

Do you have any chronic conditions?	Yes ☐ No ☐
(If yes, please select relevant condition)	TB ☐ Hypertension ☐ Diabetes ☐ Cardiac Disease ☐ 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?	Y Y Y Y M 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 Y M M D D	
Name of clinic /Vaccination site where vaccine was received			

ALLERGIES

(History of allergies not a contraindication but should be reviewed with the vaccinator)

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:*	Yes ☐ 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 ☐ No ☐
Trouble breathing	Yes ☐ No ☐
Broke out in hives	Yes ☐ No ☐
Facial or tongue swelling	Yes ☐ No ☐
Low blood pressure	Yes ☐ No ☐

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	☐ 1. Full registration	☐ 2. Section 21 approval	☐ 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 ☐ No ☐

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 *(Circle the relevant dose and record the date)*

1st Dose / 2nd Dose / 3rd 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