AGA KHAN UNIVERSITY HOSPITAL, NAIROBI

COVID-19 VACCINATION FORM

SECTION A

First name……. Middle name: ……. Last name: ……..

Gender…… DoB……. Nationality ……..

Identification type……Id No.……occupation……religion……

AKUHN staff no…….. dept… Private Physician……..

Email: …….. Phone no……

Next of kin :……. Email: ……phone:…….relationship:……..

Location details (where you are working)

County……Sub county…… Ward……Village/Estate…… Landmark: ……..

SECTION B

Temperature: ……. BP…….. Pulse rate: ……

Spo2…….....Allergies……

Chronic illness type……

Vaccination contra indication: Yes …… No…….

Reasons……..

SECTION C

Consent to receive covid-19 vaccine

I confirm I have received and understood information provided to me on covid-19 vaccination i confirm that none of the conditions above apply, or i have discussed these and/or any other special circumstances with my regular health care provider and/or vaccination service provider i agree to receive a course of covid-19 vaccine

Name …… Signature……

date of vaccination……. Time ……. Brand……

Batch number……

Site of adminstration……

Vaccinated by……...

SECTION D

adverse effects reporting

Select type of AEFTI……

Description of reactions……..

Level of care……