Ethiopian Food and Drug Authority (EFDA) REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)

*Patient's full Address: Institution: Telephone: Title & Department: Sex: M F Pregnant Lactating Address: *Date of birth: Telephone: Telephone: Email:	REPO	RTING FORM FOR ADVE	KSE EVENT:	FOLLOWII	NG IMMIC	MIZATION (AEFI	,	
*Patient's full Address:	*Patient Name or initials:				*Reporter's Name:			
Title & Department:								
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Seizures								
Severe local reaction >3 days beyond nearest joint AEFI Onset Date:// Seizures febrile afebrile AEFI Onset Time: Abscess Resolved Date (leave blank if ongoing):// Encephalopathy Resolved Time: Thrombocytopenia Describe AEFI (Signs & Symptoms):		tion				•3	-	
Severe local reaction >3 days beyond nearest joint Seizures febrile afebrile AEFI Onset Date:/ AEFI Onset Time: Resolved Date (leave blank if ongoing):// Resolved Time: Toxic shock syndrome Thrombocytopenia Describe AEFI (Signs & Symptoms):	Generalized itch							

Rash
Thrombosis

*Serious: Yes/No; → If Yes Death Life threatening Persistent Congenital anomaly Other important medical *Outcome: Recovering Recovered Recovered with seque Died If died, date of death://_Autopsy done: Yes Past medical history (including history of similar reaction or other allergies; administration (exclude those used to treat reaction) other relevant inform needed: First decision making level to complete: Investigation needed: Yes No If yes, date investigation positional level to complete: Date report received at national level//_ Comments:	ela
መጀመሪያ እዚህ ላይ እጠፍ First fold here This ADE reporting form is prepared and printed by Ethiopian Fo in collaboration with the USAID Global Health Supply Chain Prog Management (GHSC-PSM) project . Φጥሎ እዚህ ላይ እጠፍ Next fold here.	
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