MINISTRY OF HEALTH AND SOCIAL SERVICES

Vaccination Screening Form

Name of Health Facility Vaccination site is attached to:	Name of site Vaccination is administered:		
Region: _____	District: _____	☐ Outreach / Mobile	
Recipient First & Last name:	Sex ☐ Male ☐ Female	DOB: ___/___/_____ Age: ☐ Estimated Age	
Recipient's Physical Address	Identity Nr / Passport Nr.	Nationality	
Recipient's Contact details	Namibian Medical Aid ☐ Yes ☐ No	Medical Aid Name; Medical Aid No;	
Next of Kin first and Last Name	Next of Kin Contact details		

OUTCOME OF SCREENING				
VACCINATE ☒		DO NOT VACCINATE ☐		
Does the recipient fall under the vaccination eligibility stage, currently being vaccinated?	☐	Yes	☐	No

Vital Signs / Clinical Observations _____

1	Have you received a previous dose of COVID-19 vaccine? If no continue to question no 2.	☐ Yes ☐ No ☐ Unknown
1.1	Is this your second dose? *Verify vaccinate certificate.*	☐ Yes ☐ No ☐ Unknown
1.2	If this is your second dose, when was the date of your first dose? *Verify vaccinate certificate.*	___/___/_____ ☐ Unknown
1.3	If this is your second dose, which vaccine did you receive (AstraZeneca/Oxford, SinoPharm, Serum Institute of India etc)? *Verify vaccinate certificate.*	☐ Unknown
2	Are you feeling sick today? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	☐ Yes ☐ No ☐ Unknown
3	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate at home due to COVID-19 infection?	☐ Yes ☐ No ☐ Unknown
4	In the last 10 days, have been told by a healthcare provider or health department to quarantine at home due to COVID-19 exposure or travel?	☐ Yes ☐ No ☐ Unknown

5	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*	☐ Yes ☐ No ☐ Unknown
6	Have you ever had an immediate allergic reaction, such as hives, facial swelling, difficulty breathing or anaphylaxis, to any vaccine or shot or to any component of the COVID-19 vaccine, such as polyethylene glycol (PEG) or polysorbate? or a history of anaphylaxis due to any cause?	☐ Yes ☐ No ☐ Unknown
7	Have you had any vaccines in the past 14 days (2 weeks) including flu shot?	☐ Yes ☐ No ☐ Unknown
	If yes, how long ago was your most recent vaccine? Date; ___/___/_____	☐ Yes ☐ No ☐ Unknown
8	Are you pregnant?	☐ Yes ☐ No ☐ Unknown
9	Are you currently breastfeeding?	☐ Yes ☐ No ☐ Unknown
10	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes ☐ No ☐ Unknown
11	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐ Yes ☐ No ☐ Unknown
12	Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No ☐ Unknown

INFORMATION FOR HEALTH CARE PROFESSIONALS ABOUT VACCINATION ELIGIBILITY

1. Are you pregnant?

   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. Patients who are pregnant may choose to be vaccinated if they feel they are at risk after providing evidence of approval from a medical provider.

2. Are you currently breastfeeding?

   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. Patients who are lactating may choose to be vaccinated if they feel they are at risk after providing evidence of approval from a medical provider.

3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to a vaccine or injectable therapy, or a history of anaphylaxis due to any cause?

   IF YES: Please ask the patient evidence of approval from a medical provider. If they have, allow vaccination to proceed. Vaccine providers should observe patients after vaccination to monitor for the occurrence of immediate adverse reactions:
   - **Persons with a history of anaphylaxis: 30 minutes**
   - **All other persons: 15 minutes**

4. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of thevaccine?

   IF YES: Do Not Vaccinate

5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days?

   IF YES: Do Not Vaccinate