MINISTRY OF HEALTH AND SOCIAL SERVICES

COVID-19 Vaccination Register

Unique ID				
Target Group	**Phase 1**		**Phase 2**	
		Phase 1a		Phase 2a
		Phase 1b		Phase 2b
		Phase 1c		Phase 2c
		Phase 1d		Phase 2d
		Phase 1e		Phase 2e
Name of Health Facility Vaccination site is attached to:	Name of site Vaccination is administered:			
District: _____ Region: _____ ☐ 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	Next of Kin first and Last Name		Next of Kin Contact details	

Medical aid cover	Namibian Medical Aid ☐ Yes ☐ No			
	☐	NMC - Namibia Medical Care	☐	SEMAS - Public Service Medical Aid Scheme
	☐	NammedMAF - Nammed Medical Aid Fund	☐	BMED - Bankmed Namibia
	☐	NapotelMAF - Napotel Medical Aid Fund	☐	HH - Heritage Health
	☐	RCCMAF - RCC Medical Aid Fund	☐	NandebMAF - Namdeb Medical Aid Fund
	☐	RHN - Renaissance Health Namibia	☐	NHP - Namibia Health Plan
	☐	WBMAF - Woermann Brock Medical Aid Fund	☐	Non – Foreign Medical Aid
	☐	Other Specify (Only Specify other Namibian Medical Aid if not listed above;		
Occupation by category	☐	Healthcare worker;	☐	Retail (non essential);
	☐	Law enforcement/	☐	Social worker/ volunteer;
	☐	Firefighter;	☐	Retired;
	☐	Banker;	☐	Immigration Officers;
	☐	Driver / housekeeping staff;	☐	Student;
	☐	Teacher;	☐	Unemployed;
	☐	Hotelier / airline personnel;	☐	Other, Specify;
	☐	Retail (essential);	☐	

Consent for vaccination Obtained	☐ Yes ☐ No	**Screened for Eligibility**	☐ Yes ☐ No
Pregnantcy Information	**Is patient Pregnant /Lactating**		☐ Yes ☐ No
	If Pregnant, indicate Gestation period		Nr

Co-morbidities	☐	001 Pregnancy;	☐	008 Renal Disease;
	☐	002 Immunodeficiency Syndrome;	☐	009 Underlying condition Other;
	☐	003 Cardiovascular Disease;	☐	010 Obesity;
	☐	004 Chronic Lung Disease;	☐	011 Hypertension + Iscahemic Heart Disease;
	☐	005 Diabetes;	☐	012 Pulmonary TB + Chronic Resp. Diseases;
	☐	006 Malignancy;	☐	013 PLHIV alone and/or with co-morbidity;
	☐	007 Neurological/Neuromuscular;	Other Specify;	

History of allergic reaction Yes/No (if yes specify below)		
For clients that have been confirmed positive for SARS CoV-2 virus indicate date of confirmed result		_____/_____/_____
Dose 1 vaccination	**Date of Dose 1 vaccination**	_____/_____/_____
	Dose 1 vaccine name	
	Dose 1 Manufacturer	
	Batch / Lot Nr	
	Vaccine Expiry Date	_____/_____/_____
	Date of Next Vaccine	_____/_____/_____
	Adverse Event	**Yes/No**
	Adverse Event	**Minor/Severe/ Serious**
	Date of Adverse event	_____/_____/_____
	Additional Comments (optional)	
	Vaccinator's Full Name	
	Vaccinator's Signature	
Dose 2 vaccination	**Date of Dose 2 vaccination**	_____/_____/_____
	Dose 2 vaccine name	
	Dose 2 Manufacturer	
	Batch / Lot Nr	
	Vaccine Expiry Date	_____/_____/_____
	Date of Next Vaccine	_____/_____/_____
	Adverse Event	**Yes/No**
	Adverse Event	**Minor/Severe/ Serious**
	Date of Adverse event	_____/_____/_____
	Additional Comments (optional)	
	Vaccinator's Full Name	
	Vaccinator's Signature	
Dose 3 vaccination	**Date of Dose 3 vaccination**	_____/_____/_____
	Dose 3 vaccine name	
	Dose 3 Manufacturer	
	Batch / Lot Nr	
	Vaccine Expiry Date	_____/_____/_____
	Date of Next Vaccine	_____/_____/_____
	Adverse Event	**Yes/No**
	Adverse Event	**Minor/Severe/ Serious**
	Date of Adverse event	_____/_____/_____
	Additional Comments (optional)	
	Vaccinator's Full Name	
	Vaccinator's Signature	

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;	
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 _____

	Have you received a previous dose of COVID-19 vaccine? If no continue to question no 2.	□ Yes □ No □ Unknown
.1	Is this your second dose? *Verify vaccinate certificate.*	□ Yes □ No □ Unknown
.2	If this is your second dose, when was the date of your first dose? *Verify vaccinate certificate.*	__/__/____ □ Unknown
.3	If this is your second dose, which vaccine did you receive (AstraZeneca/Oxford, SinoPharm, Serum Institute of India etc)? *Verify vaccinate certificate.*	□ Unknown
	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
	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
	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 the vaccine?

   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?

NAMIBIA COVID-19 VACCINATION CONSENT FORM

Health Facility:		District :	Region:
Type of vaccination site:	Mobile ☐ Outreach ☐ Fixed ☐	Physical Address	
Recipient Full name (Name & Surname):		Sex at Birth ☐ Male ☐ Female	DOB: ___/___/_____

Health Workers must review sections below with the client to obtain consent

EMERGENCY USE AUTHORIZATION

The Ministry of Health and Social Services / Namibia Medicine Regulatory Council has made COVID-19 vaccines available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency health situation, such as the COVID-19 pandemic.

CONSENT

1. I have been provided with and have read/have been explained in my own language, the nature of the vaccine, the facts about the said vaccine has been provided to me.
2. I understand that if this vaccine requires two doses, the two doses of this vaccine shall be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction/ I have ensured that the person named above for whom I am authorised to provide consent was also given a chance to ask question (In case of guardian). I understand the benefits and known side effects of the vaccine.
3. I give permission for the vaccine to be administered to me/the person named above for whom I am authorised to make this request and provide consent (in case of a guardian).
4. I have been informed that after administration of the vaccine, I will be kept under observation for a period for up to 30 minutes.
5. I authorise the release of all information needed, including but not limited to medical records as may be required for other public health purposes.

WAIVER

1. I acknowledge that vaccination like other medicines may have some known side effects. Adverse events following immunisation that may occur have explained to me.
2. I voluntarily seek and accept vaccination for COVID-19.
3. I have read/heard and fully understand the contents of this consent form and I execute it voluntarily.
4. I undertake to attend the same vaccination centre on the date scheduled for the second dose (for vaccines requiring two doses).

Recipient/Surrogate/Guardian (Signature): _____

Date: ___/_____/_____ Print Name: _____

Relationship to patient, if other than recipient: _____

Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today?

Vaccine Name:			Dose administered:	☐ First Dose	☐ Second Dose	☐ Third Dose		
Administration Site	☐ Left Deltoid	☐ Right Deltoid	☐ Left Thigh	☐ Right Thigh	Dosage	☐ 0.5 ml	☐ 0.3 ml	

☐ I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____

Vaccinator Name and Surname: _____

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