COVID-19 V02-29032021

MINISTRY OF HEALTH AND SOCIAL SERVICES

COVID-19 Vaccination Register

Unique ID

Name of Health Facility Vaccination site is attached to: ______

Name of site Vaccination is administered: ______

District: ______

Region: ______ ☐ Outreach / Mobile

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
☐ Other	

Recipient First & Last name:	Sex ☐ Male ☐ Female	Lactating ☐ Yes ☐ No Pregnant ☐ Yes ☐ No Gestation Period: ______
Identity Nr / Passport Nr. Nationality Recipient's:	DOB: __/__/____ Age: Estimated age	Physical Address

Recipient's Contact details:	Next of Kin first and Last Name	Next of Kin Contact details

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);		

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;		

Consent for vaccination Obtained	☐ Yes ☐ No	**Screened for Eligibility**	☐ Yes ☐ No

☐	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;	

...S

...lergic reaction Yes/No (if yes specify below)

...hat have been confirmed positive for SARS ... indicate date of confirmed result	____/____/____
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	
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	
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	