


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: _____ <input type="checkbox"/> Outreach / Mobile	
Recipient First & Last name:		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB: ___/___/___ Age: _____ <input type="checkbox"/> Estimated Age
Recipient's Physical Address		Identity Nr / Passport Nr.	Nationality
Recipient's Contact details:	Namibian Medical Aid <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Aid Name;	
Next of Kin first and Last Name		Next of Kin Contact details	
OUTCOME OF SCREENING			
VACCINATE <input type="checkbox"/>		DO NOT VACCINATE <input type="checkbox"/>	
Does the recipient fall under the vaccination eligibility stage, currently being vaccinated?		<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vital Signs /			
Clinical			
Observations			
1	Have you received a previous dose of COVID-19 vaccine? If no continue to question no 2.	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
1.1	Is this your second dose? <i>Verify vaccinate certificate.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
1.2	If this is your second dose, when was the date of your first dose? <i>Verify vaccinate certificate.</i>	___/___/___	<input type="checkbox"/> Unknown
1.3	If this is your second dose, which vaccine did you receive (AstraZeneca/Oxford, SinoPharm, Serum Institute of India etc)? <i>Verify vaccinate certificate.</i>		<input type="checkbox"/> 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.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown

5	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? <i>If yes, when did you receive the last dose?..</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
7	Have you had any vaccines in the past 14 days (2 weeks) including flu shot?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	<i>If yes, how long ago was your most recent vaccine?</i> Date; ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
8	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
9	Are you currently breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
10	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
12	Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?