Directorate General Health Services Sindh Hyderabad
Regional Disease Surveillance and Response Unit
EX I & I Depot Rafiqui Shaheed Road near JPMC Karachi Cantt, Phone # 02135167029
Phone No. 022-9240101-6, Fax No. 022-9240100: Email: dghealthsindh@sindhealth.pk

FELTP-PAKISTAN
Field Epidemiology & Laboratory Training Program

COVID-19 Vaccine Registration Proforma
(CV-Form 01)

Serial Number						
Vaccine Site Name						
NIMS Registration #						
Dated						
Shift	Morning		Evening		Night	
Name:						
Age						
Gender						
Contact #						
NIC #						
Address with Town/Taluka:						
District of residence						
Current Place of Posting (Including District)						
Sector	Public			Private		
Designation						
HCW category	Medics	Nurse	Paramedics	Supportive	Janitorial	Other (Mention it)
Extent of COVID – 19 Involvement	Front Line			Second Line		
H/of COVID-19 Infection	Yes		No		Don't Know	
If Yes Please provide details	Date OR Month of Diagnosis					
	History of Hospitalization		Yes		No	

I hereby declare that all the given information are accurate

Signature

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Pre-Vaccination Evaluation Check List for COVID-19 Vaccines Recipients (CV Form 2)

Verification Code | | | | | | |

NIC # | | | | | | - | | | | | | | | | - | |

Vaccine Site Name _____ Town/Taluka _____

Dated _____ District /Division _____

Desk B

Personal Profile		Vitals Recoding	
Full Name		Temperature	
Age		Pulse	
Gender		Blood Pressure	
Designation		Respiratory Rate	
Contact #		Others	
Place of Posting		Others	
Assigned Person Name		Assigned Person Name	
Signature		Signature	

Desk C

S No	Check List of Medical History	Yes	No	Don't Know
1	Are you feeling sick today			
2	Have you been ever vaccinated for COVID-19			
3	Have you received any vaccine in last 10-14 days			
4	Have you any allergy with any food product			
5	Have you any allergy with any medical product			
6	Have you any know disease currently			
7	Have you ever positive tested for COVID-19			
8	Have you received passive antibody therapy as treatment for COVID-19			
History of Any Chronic Illness				
9	Have you any know disease previously (If Yes tick below diseases)			
	History of fits/seizures or a brain (CNS) related issue			
	Cardiovascular disease			
	Diabetes Mellitus			
	Hepatitis B or C			
	Leukemia			
	Cancer			
	HIV/AIDS			
	Any Other Disease			
History of Any Medication				
10	Are you on medication for any disease (If Yes Please ask and write)			
	Name of Medicine			
History of any Therapy				
11	Have you any history of Surgery or organ transplantation)			
	Name of Surgery or Transplantation			
12	Have you received any transfusion of blood or Blood Product in last 4 months			
Only For Female Recipients				
13	Are you pregnant currently (for child bearing age female group)			
14	Are you currently breast feeding to any child/children			

Remarks _____

Assigned Person Name: _____ **Signature:** _____