**DCF03 - Immunization History**

*Complete this form for each enrolled child.*

Q1. Date of the visit *required*

*For each vaccine listed below, indicate the child \_\_\_\_ has received the vaccine and if so, on what date.*

Q2. Where does the vaccination information come from? *required*

* health card
* caregiver statement

Q3. BCG *required*

* Yes
* No
* Unknown

Q4. Date of BCG *required*

Q5. Polio 0 *required*

* Yes
* No
* Unknown

Q6. Date of Polio 0 *required*

Q7. Polio 1 *required*

* Yes
* No
* Unknown

Q8. Date of Polio 1 *required*

Q9. Polio 2 *required*

* Yes
* No
* Unknown

Q10. Date of Polio 2 *required*

Q11. Polio 3 *required*

* Yes
* No
* Unknown

Q12. Date of Polio 3 *required*

Q13. Pentavalent 1 (DPT-HiB-HBV) *required*

* Yes
* No
* Unknown

Q14. Date of Pentavalent 1 *required*

Q15. Pentavalent 2 *required*

* Yes
* No
* Unknown

Q16. Date of Pentavalent 2 *required*

Q17. Pentavalent 3 *required*

* Yes
* No
* Unknown

Q18. Date of Pentavalent 3 *required*

Q19. S. pneumococcus (PCV13) 1 vaccine dose *required*

* Yes
* No
* Unknown

Q20. Date of S pneumococcus (PCV13) 1: *required*

Q21. S. pneumococcus (PCV13) 2 vaccine dose *required*

* Yes
* No
* Unknown

Q22. Date of S pneumococcus (PCV13) 2: *required*

Q23. S. pneumococcus (PCV13) 3 vaccine dose *required*

* Yes
* No
* Unknown

Q24. Date of S pneumococcus (PCV13) 3: *required*

Q25. Rotavirus (Rotateq) 1: *required*

* Yes
* No
* Unknown

Q26. Date of Rotavirus (Rotateq) 1: *required*

Q27. Rotavirus (Rotateq) 2: *required*

* Yes
* No
* Unknown

Q28. Date of Rotavirus (Rotateq) 2: *required*

Q29. Rotavirus (Rotateq) 3: *required*

* Yes
* No
* Unknown

Q30. Date of Rotavirus (Rotateq) 3: *required*

Q31. Measles (VAR - vaccin anti-rougeole) *required*

* Yes
* No
* Unknown

Q32. Date of Measles (VAR - vaccin anti-rougeole): *required*

Q33. Yellow Fever (VAA - vaccin anti-amarile) *required*

* Yes
* No
* Unknown

Q34. Date of Yellow Fever (VAA - vaccin anti-rougeole): *required*

Q35. Meningococcal A (Men Afrivac): *required*

* Yes
* No
* Unknown

Q36. Date of Meningococcal A (Men Afrivac): *required*

Q37. Seasonal Malaria Chemoprevention (SMC) *required*

* Yes
* No
* Unknown

Where does the information for SMC come from? *required*

* SMC Card
* Caregiver statement

Q38. How many doses of SMC has the infant received since the previous LAKANA visit or in the three months prior to MDA 1?: *required*

Q39. Date of latest SMC dose *required*

Q40. Vitamin A (received since previous LAKANA visit): *required*

* Yes
* No
* Unknown

Q41. Date of Vitamin A: *required*

*Form completed. \*\*Please fill the form for other eligible children\*\* If the form is filled for enrolled children, fill form DCF04 in section \*\*Household\*\**