**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\*\**