7 CA 9/2/19

ILARI SIW 2860

IMMUNIZATIONS

PROTECT YOUR CHILD

BCG VACCINE: at birth	Date Given	Date of next visit
(Intra-dermal left fore arm)		CA YOUNG
Dose: (0.05mls for child below 1 year)	20/05/14	2/7/14
Dose: (0.1 mls for child above 1 year)	7	1
BCG-Scar Checked	Date checked	Date BCG repeated
PRESENT		
ABSENT	11.7	

ORAL POLIO VACCINE (OPV)	Date Given	next Visit
Dose: 2 drops orally		
Birth Dose: at birth or within 2 wks (OPV 0)	20/05/14	2/7/14
1st dose at 6 weeks (OPV 1)	2/2/14	41814
2nd dose at 10 weeks (OPV 2)	418/14	4112
3rd dose at 14 weeks (OPV 3)	4/07/2014	

DIPHTHERIA/PERTUSSIS/TETANUS/HEPATITIS B/ HAEMOPHILUS INFLUENZAE Type b	Date Given	Date of next visit
Dose:(0,5mls) Intra Muscular left outer thigh	COOM.	
1st dose at 6 weeks	2/3/14	41814
2nd dose at 10 weeks	N184	4/9/14
3rd dose at 14 weeks	H10912014	14/10/20V

PNEUMOCOCCAL VACCINE	Date Given	Date of next visit
Dose:(0.5mls) Intra Muscular right outer thigh		
1st dose at 6 weeks	21744	A1814
2nd dose at 10 weeks	418/14	41214
3rd dose at 14 weeks	4 09 2014	4/61/2014

2nd dose at 10 weeks*

ROTA VIRUS VACCINE (ROTARIX)

Date given

Date of next visit

Dose: 1.5mls orally 1st dose at 6 weeks

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Tea 6/11/14 7 M 18/19 19 19 19 NOT FOR SALE 121 2015

a Measles outbreak or HIV Exposed children (HEI)	
Dose: (0.5mls) Subcutaneously right upper arm	100/2015

a Measles outbreak or HIV Exposed children (HEI)	THE RESIDENCE OF THE PARTY OF T
Dose: (0.5mls) Subcutaneously right upper arm	13/03/2015
MEASLES VACCINE at 9 Months	Date Given
Dose: (0.5mls) Subcutaneously right upper arm	
MEASLES VACCINE at 18 Months	Date Given
Dose: (0.5mls) Subcutaneously right upper arm	
YELLOW FEVER VACCINE at 9 Months**	Date Given
Dose: (0.5mls) Intra Muscular left upper deltoid	

^{**} Only in selected districts in Rift Valley

Other Vaccines

Vaccine	Note that the second second
	STANDARD STA
	-9
	300

NB: Other vaccines refer to those not in the usual KEPI schedule and may include MMR, Typhoid etc.

If your child develops any adverse events following immunization (AEFI) Please report immediately to the nearest health facility

ANY AD	ANY ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)
DATE:	
DESCRIBE:	
ANTIGEN/VACCINE:	
BATCH NUMBER:	
MANUFACTURE DATE:	
EXPIRY DATE:	
MANUFACTURER'S NAME:	