**HEALTH VISITOR DIARY CARD**

**Kawempe National Referral Hospital**

**ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In case of emergency:**

**24-hour study contact: XXXX XXX XXX / XXXX XXX XXX**

**Instructions:**

**Please complete the following sections regarding symptoms which may have been experienced, on day three following vaccination and then day ten.**

**Vaccination #: (Circle the appropriate) 1 2**

**Day post vaccination (circle the appropriate day for the visit): Day 3 OR Day 10**

**Temperature** (As measured with thermometer):

Is there history of fever (circle the right response**): Yes** **No**

If yes probe for any need for medication or hospital visit and feel details below.

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**Injection site Local Reactions (Tick the corresponding grade):**

Injection site redness:

|  |  |  |  |
| --- | --- | --- | --- |
| **None (0)** | **Mild (1)** | **Moderate (2)** | **Severe (3)** |
| No redness at the vaccination site | Redness that is equal to or less than 25 mm | Redness that is greater than 25 mm but covers less than half the upper arm | Redness that covers more than half the thigh/upper arm OR there is an open wound OR evidence of infection, pus, or clear liquid draining from the site that was injected |

Injection site swelling:

|  |  |  |  |
| --- | --- | --- | --- |
| **None (0)** | **Mild (1)** | **Moderate (2)** | **Severe (3)** |
| No swelling or hardness of skin at the injection site | Swelling/hardness that is equal to or less than 25 mm | Swelling/hardness that is greater than 25 mm but covers less than ½ the thigh/upper arm region | Swelling/hardness that covers more than ½ the thigh/upper arm OR with an open wound OR evidence of infection, pus, or clear liquid draining from the site that was injected |

Injection site pain:

|  |  |  |  |
| --- | --- | --- | --- |
| **None (0)** | **Mild (1)** | **Moderate (2)** | **Severe (3)** |
| No pain at the injection site | Minor reaction indicating pain after gently touching the injection site | Gently touching the injection site causes pain | Pain if the injected limb is moved (spontaneously or by field worker) |

**General Reactions (Tick the corresponding grade):**

Rash:

|  |  |  |  |
| --- | --- | --- | --- |
| **None (0)** | **Mild (1)** | **Moderate (2)** | **Severe (3)** |
| No rash or blisters anywhere on the body | Red spots only on a small area of skin. | Red spots (flat or raised) scattered all over the skin OR large red areas on the skin | Red spots (flat or raised) scattered all over the skin with blistering OR a single blister on a mucous membrane |

Headache:

|  |  |  |  |
| --- | --- | --- | --- |
| **None (0)** | **Mild (1)** | **Moderate (2)** | **Severe (3)** |
| no headache | small headache lasting only an hour or so | headache all over the head | unable to see, being sick |

Drowsiness:

|  |  |  |  |
| --- | --- | --- | --- |
| **None (0)** | **Mild (1)** | **Moderate (2)** | **Severe (3)** |
| No symptoms | more sleepy but there is no change in normal activities | sleeping so much that it is affecting normal activities | unable to perform any normal activity due to sleepiness |

Muscle aches:

|  |  |  |  |
| --- | --- | --- | --- |
| **None (0)** | **Mild (1)** | **Moderate (2)** | **Severe (3)** |
| No symptoms | one or two muscle aches but no change in normal activities | one or two muscle aches that are affecting normal activities | all over aches and unable to do any normal activities |

**Did you experience any medical problems that was not asked in the previous page? Please enter the information in the table below.**

|  |  |  |
| --- | --- | --- |
| **Medical problem** | **Date Started** | **Date Stopped** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Medication Use (please enter the name of the medication, the dates the medication were used and the reason for using the medication)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date medication taken** | **Date medication stopped** | **Medication name (including how many times taken** | **Reason for taking medication** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Did you need to go to hospital for any medical problems or treatment: Yes / No**

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Health visitor name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials and EMPID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

DD MMM YYYY

**Investigator Review of Diary Card and assessment notes:**

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Investigator’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials and Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

DD MMM YYYY