

**NATIONAL HEALTH MANAGEMENT
CHILD IMMUNIZATION**

1. STATE _____ 2. LGA _____

5. BIRTH MONTH _____

Write date child received each vaccination in the boxes

7. S/N	8. DATE OF CHILD'S VISIT (day/month/year)	9. CHILD'S NAME	10. CHILD'S CARD NO.	11. SEX (M/F)	12. CHILD'S FOLLOW UP ADDRESS	13. PHONE NUMBER	14. DOB (day/month/year)	OPV 0 (Birth)	Hep.B 0 (Birth)	BCG	OPV 1	PENTA1	PCV1	OPV2	PENTA2	PCV2

HEALTH OFFICER FULL NAME: _____

SIGNATURE OF HEALTH OFFICER _____

INFORMATION SYSTEM REGISTER

3. WARD _____ 4. HEALTH FACILITY _____

6. BIRTH YEAR _____

OPV3	PENTA3	PCV3	VITAMIN A		MEASLES 1	YELLOW FEVER	MEASLES 2	CONJUGATE A CSM	DPT1	DPT2	DPT3	Hep. B1	Hep. B 2	COMMENTS (IF ANY)
			6 -11	12 - 23										

HEAD OF UNIT FULL NAME: _____

SIGNATURE OF HEAD OF UNIT _____

1. STATE _____ 2. LGA _____ 3. WARD _____

6. S/N	7. DATE	8. SESSION TYPE FIXED (F) or OUTREACH (O)	OPV 0 (Birth)	Hep.B 0 (Birth)	BCG	OPV 1	PENTA1		PCV1	OPV2		PENTA2		PCV2		OPV3	PENTA3		PCV3			
			0 - 2 WEEKS	0 - 2 WEEKS	0 - 11 MONTHS	6 WEEKS - 11 MONTHS	12 -23 MONTHS	6 WEEKS - 11 MONTHS	12 -23 MONTHS	6 WEEKS - 11 MONTHS	12 -23 MONTHS	10 WEEKS - 11 MONTHS	12 -23 MONTHS	10 WEEKS - 11 MONTHS	12 -23 MONTHS	10 WEEKS - 11 MONTHS	12 -23 MONTHS	14 WEEKS - 11 MONTHS	12 -23 MONTHS	14 WEEKS - 11 MONTHS	12 -23 MONTHS	14 WEEKS - 11 MONTHS
TOTAL																						

NAME OF M&E/ STATISTICS OFFICER _____ SIGNATURE OF M&E/STATISTICS OFFICER _____ DATE COMPLETED _____

INFORMATION SYSTEM
IMMUNIZATION SUMMARY

4. HEALTH FACILITY _____ **5. MONTH/YEAR** _____

VITAMIN A		MEASLES 1		YELLOW FEVER		MEASLES 2	CONJUGATE A CSM	TETANUS TOXOID 9WOMEN 15-49 YEARS								LLIN		
6 - 11 MONTHS (100,000 IU)	12 - 23 MONTHS (200,000 IU)	9 - 11 MONTHS	12 - 23 MONTHS	9 - 11 MONTHS	12 - 23 MONTHS	18 - 23 MONTHS		1ST		2ND		3RD		4TH			5TH	
								P	NP	P	NP	P	NP	P	NP		P	NP

NAME OF HEAD OF UNIT _____ SIGNATURE OF HEAD OF UNIT _____ DATE COMPLETED _____