


# Appendix F

IMMUNISATIONS				
Batch no:	Vaccine	Site	Date given day / month / year	Signature
	BCG	Right arm	/ /	
	Polio 0	Oral	/ /	
	Polio 1	Oral	/ /	
	DTP 1	Left thigh	/ /	
	Hib 1	Left thigh	/ /	
	DTP 2 / Hib 2 (combined)	Left thigh	/ /	
	Hep B 1	Right thigh	/ /	
	Polio 2	Oral	/ /	
	DTP 2	Left thigh	/ /	
	Hib 2	Left thigh	/ /	
	DTP 2 / Hib 2 (combined)	Left thigh	/ /	
	Hep B 2	Right thigh	/ /	
	Polio 3	Oral	/ /	
	DTP 3	Left thigh	/ /	
	Hib 3	Left thigh	/ /	
	DTP 3 / Hib 3 (combined)	Left thigh	/ /	
	Hep B 3	Right thigh	/ /	
	Measles 1	Right thigh	/ /	
	Polio 4	Oral	/ /	
	DTP 4	Left arm	/ /	
	Measles 2	Right arm	/ /	
	Polio 5	Oral	/ /	
	DT 1	Left arm	/ /	

PRIMARY SCHEDULE

BOOSTERS				
Batch no:	Vaccine	Site	Date given day / month / year	Signature



**Road to Health Chart**  
IMPORTANT: always bring this chart when you visit any health clinic, doctor or hospital and present the chart on school entry

GDH 8/133

Child's name: \_\_\_\_\_ boy  girl

Child's ID number: \_\_\_\_\_

Date of birth: \_\_\_\_\_ day / month / year \_\_\_\_\_ Place of birth: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ Birth head circumference: \_\_\_\_\_

Problems during pregnancy / birth / neonatally: \_\_\_\_\_

APGAR 1 min: \_\_\_\_\_ Gestational age (wks): \_\_\_\_\_ Mother's Serology: \_\_\_\_\_

5 min: \_\_\_\_\_ Antenatal: \_\_\_\_\_ Delivery: \_\_\_\_\_

RHC information given by: \_\_\_\_\_

Mother's name: \_\_\_\_\_

Father's name: \_\_\_\_\_

Who does the child live with? \_\_\_\_\_

How many children has the mother had?  
Number born: \_\_\_\_\_ alive now: \_\_\_\_\_ Date of last birth: \_\_\_\_\_ day / month / year \_\_\_\_\_

Reason(s) for death(s): \_\_\_\_\_

**Visual screening**

Result: L: (yes  no  R: (yes  no  Date tested: \_\_\_\_\_ day / month / year \_\_\_\_\_

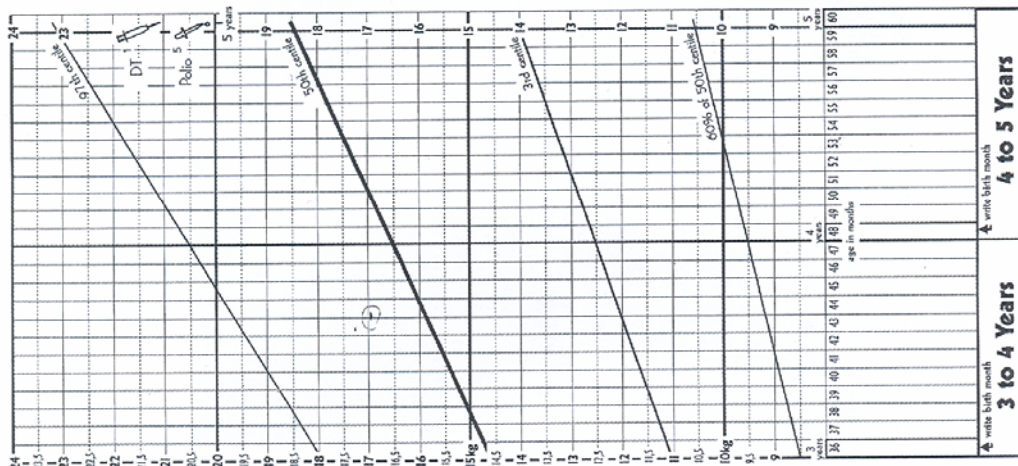
Result: L: / / R: / / Date tested: \_\_\_\_\_ day / month / year \_\_\_\_\_

**Hearing screening**

Result: Yes  No  Date tested: \_\_\_\_\_ day / month / year \_\_\_\_\_

Result: L: (yes  no  R: (yes  no  Date tested: \_\_\_\_\_ day / month / year \_\_\_\_\_

Result: L: / / R: / / Date tested: \_\_\_\_\_ day / month / year \_\_\_\_\_



**In need of special care (mark with X)**

Was the baby less than 2.5kg at birth?    Yes  No     Are any brothers or sisters underweight?    Yes  No

Is the baby a twin?    Yes  No     Is the baby bottle fed?    Yes  No

Household TB contact?    Yes  No     Does the mother need more family support?    Yes  No

Are there any reasons for taking extra care?    Yes  No     (for example: single parent etc.) \_\_\_\_\_

Address of clinic(s) visited:  
Clinic 1: \_\_\_\_\_  
Clinic 2: \_\_\_\_\_





