

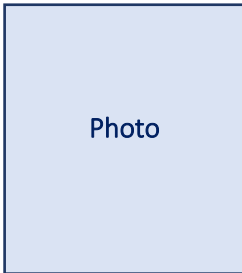


International Organization for Migration (IOM)
The UN Migration Agency

Migration Health Assessment VACCINATION WORKSHEET

Form MH01-F

A1	Destination Country:
A2	Migrant Type: <input type="checkbox"/> IMM <input type="checkbox"/> REF <input type="checkbox"/> OTHER
A3	Case No.:
A4	Alien No.:
A5	IME No.:
A6	UNHCR No.:
A7	Passport No.:



Biographic Information			
A8	Name: _____ (Family) (First) (Middle)		
A9	Date of Birth:	A12	Country of Current Residence:
A10	Sex: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> I		
A11	Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> MT <input type="checkbox"/> FT <input type="checkbox"/> U	A13	Nationality:

F = Female, M = Male, I = Indeterminate, N = Non-conforming, MT = Transgender Female, FT = Transgender Male, U = Unknown

F14 Vaccination Record									
Vaccine History Transferred from a Written Record <i>List Chronologically from Left to Right. Provide date as dd-mmm-yyyy.</i>					Additional Vaccine Doses Given by Panel Site			Test for Immunity, if positive	Reasons for Non- Vaccinations*
Vaccine	Date	Date	Date	Date	Date	Date	Date	Date	A, B, C**, D, F, H, R
Diphtheria, tetanus, pertussis <input type="checkbox"/> DTP, DTaP									
<input type="checkbox"/> DT									
<input type="checkbox"/> Td									
<input type="checkbox"/> Tdap									
<input type="checkbox"/> TT									
Polio <input type="checkbox"/> OPV									
<input type="checkbox"/> IPV									
Measles, mumps, rubella <input type="checkbox"/> MMR									
<input type="checkbox"/> MR									
<input type="checkbox"/> Measles									
<input type="checkbox"/> Mumps									
<input type="checkbox"/> Rubella									
Rotavirus <input type="checkbox"/> RotaTeq (RV5)									
<input type="checkbox"/> Rotarix (RV1)									
Hib									
Hepatitis A									
Hepatitis B									
Meningococcal <input type="checkbox"/> MenACWY Conjugate <i>(specify brand in remarks)</i>									
<input type="checkbox"/> Other meningococcal vaccine <i>(specify type in remarks)</i>									
Varicella <input type="checkbox"/> Vaccine <input type="checkbox"/> Varicella history									
Pneumococcal <input type="checkbox"/> PCV 7									
<input type="checkbox"/> PCV 10									
<input type="checkbox"/> PCV 13									
<input type="checkbox"/> PPSV 23									
Influenza									
Human papillomavirus									
COVID-19									
Other									

*Reasons for non-vaccinations, legend:

A = Not age appropriate, B = Insufficient time interval to complete series, **C Record the specific Contraindication reason (C1 = Current pregnancy; C2 = Immune compromised; C3 = History of severe allergic reaction to vaccine or vaccine component; C4 = Other severe reaction to vaccine; C5 = Current moderate to severe illness; C6 = Other, specify in remarks), D = Not routinely available, F = Flu vaccine not available, H = Known chronic hepatitis B virus infection, R = Refusal

F15	Vaccination remarks
F16	Panel Physician Name:
F17	Panel Physician Signature:
F18	Signature Date: