

Health Facility:					Year:							
To be completed monthly by the Professional Nurse responsible for IMCI. Please indicate which of the following items are available/compliant N (No) = not available or not functional; Y (Yes) = available and functional Y = 1 , N = 0												
Date:	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
A. Vaccine conditions adequate												
1 Adequate number of ice packs												
2 Cool boxes in consulting rooms												
3 Functioning refrigerator and cool box thermometers												
4 Correct vaccine conditions maintained (2- 8°C)												
5 Vaccines properly stored												
6 Vaccine Vial Monitor												
7 Cold Chain monitoring												
8 Temperature chart on fridge checked daily												
9 Vaccine vial monitoring correctly monitored												
10 Fridge thermometers at correct temperature												
11 Vaccines packed correctly in fridge												
12 Vaccine stock charts checked												
B. Guidelines available												
13 Vaccinators Manual												
14 Cold Chain Manual												
15 Surveillance Manuel												
16 BCG												
17 DaPT-IPV-HB-Hib												
18 Measles												

Date :	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
19 OPV												
20 PCV												
21 RV												
22 Td												
C. Adverse event following immunization monitored												
23 Adverse reports available in file												
A. Totals:												
B. Total Possible:	23	23	23	23	23	23	23	23	23	23	23	23
Divide A by B:												
Final Percentage (x100)	%	%	%	%	%	%	%	%	%	%	%	%
Recorded Score on Child Health Dashboard	☐ Yes											
Record Remedial Actions on QIP	☐ Yes											
Sign												
Designation				·		·						•