



**2. ANAPHYLAXIS OR OTHER ALLERGIC REACTION:** Choose the one that best fits the AEFI and provide details in Supplementary Information section.

Temporal characteristics	Choose the single most appropriate period of time (either Min, Hrs, or Days) ☛ Time from immunization to 1st symptom/sign onset: __Min __Hrs __Days ☛ Time from onset of 1st symptom/sign to resolution of all symptoms/signs: __Min __Hrs __Days
<input type="checkbox"/> <b>*Anaphylaxis:</b> Rapid onset and involving at least 2 body systems. Check all involved systems below and list specific symptoms/signs for each checked box in the Supplementary Information section. ___Dermatologic/Mucosal ___Cardiovascular ___Respiratory ___Gastrointestinal	
<input type="checkbox"/> <b>Other Allergic Reaction</b> Describe in Supplementary Information section	

**3. NEUROLOGIC REACTION:** Check all applicable boxes; provide details in Supplementary Information section.

Temporal characteristics	Choose the single most appropriate period of time (either Min, Hrs, or Days) ☛ Time from immunization to 1st symptom/sign onset: __Min __Hrs __Days ☛ Time from onset of 1st symptom/sign to resolution of all symptoms/signs: __Min __Hrs __Days
<input type="checkbox"/> <b>*Encephalopathy / Encephalitis</b> Check all that apply. Add details in Supplementary Information section. <ul style="list-style-type: none"> <li><input type="checkbox"/> Depressed/altered level of consciousness, lethargy or personality change lasting for ≥24hrs</li> <li><input type="checkbox"/> focal or multifocal neurologic sign(s) <span style="margin-left: 150px;"><input type="checkbox"/> Fever ≥ 38.0C</span></li> <li><input type="checkbox"/> CSF pleocytosis &gt;5 wbc/mm<sup>3</sup> <span style="margin-left: 150px;"><input type="checkbox"/> Seizures (if present, provide details in seizure section below)</span></li> <li><input type="checkbox"/> EEG consistent with encephalitis <span style="margin-left: 150px;"><input type="checkbox"/> Neuroimaging consistent with encephalitis</span></li> <li><input type="checkbox"/> Brain pathology consistent with encephalitis</li> </ul>	
<input type="checkbox"/> <b>*Meningitis</b> Record symptoms and CSF results in Supplementary Information section.	
<input type="checkbox"/> <b>Seizure(s)</b> Check all that apply and provide a detailed description of the seizure in the Supplementary Information section (generalized, focal, or focal progressing to generalized; tonic, clonic, tonic-clonic or atonic motor manifestations; automatisms (e.g. drooling, lip smacking); loss of awareness (fixed stare, eye deviation, inability to communicate). <ul style="list-style-type: none"> <li><input type="checkbox"/> Sudden loss of consciousness -if ticked was it:                         <ul style="list-style-type: none"> <li><input type="checkbox"/> Witnessed by healthcare professional <b>OR</b> <input type="checkbox"/> By report only</li> </ul> </li> <li><input type="checkbox"/> Associated with fever <span style="margin-left: 50px;"><input type="checkbox"/> History of seizures before immunization: <input type="checkbox"/> febrile <input type="checkbox"/> afebrile <input type="checkbox"/> unknown type</span></li> </ul>	
<input type="checkbox"/> <b>*Guillain-Barré Syndrome</b> (Indicate in Supplementary Information section whether EMG and/or LP done, and results, as well as any other relevant investigation including tests to look for possible causes, especially Campylobacter)	
<input type="checkbox"/> <b>*Bell's Palsy</b>	
<input type="checkbox"/> <b>*Paralysis other than Bell's Palsy</b> Describe in Supplementary Information section.	

**4. OTHER DEFINED AEFIS OF INTEREST:** Complete temporal characteristics, check all applicable boxes and provide any important additional details in Supplementary Information section.

Temporal characteristics	Choose the single most appropriate period of time (either Min, Hrs, or Days) ☛ Time from immunization to 1st symptom/sign onset: __Min __Hrs __Days ☛ Time from onset of 1st symptom/sign to resolution of all symptoms/signs: __Min __Hrs __Days
<input type="checkbox"/> <b>Hypotonic-Hyporesponsive Episode:</b> (NOTE: only if <2yrs old. If older, check "other severe or unusual event" and describe in Supplementary Information section) <b>Check all that apply</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Limpness <input type="checkbox"/> Reduced responsiveness / unresponsiveness <input type="checkbox"/> Pallor/Cyanosis</li> </ul>	
<input type="checkbox"/> <b>Persistent Crying</b> (Crying which is continuous and unaltered for ≥ 3 hours)	
<input type="checkbox"/> <b>Rash</b> <input type="checkbox"/> Generalized <input type="checkbox"/> Localized at injection site <input type="checkbox"/> Localized at non-injection site	
<input type="checkbox"/> <b>Arthritis</b> (joint pain lasting at least 24 hours). <b>Check all that apply:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Joint swelling <span style="margin-left: 100px;"><input type="checkbox"/> Joint redness</span></li> <li><input type="checkbox"/> Sensation of warmth over joint <span style="margin-left: 100px;"><input type="checkbox"/> Inflammatory changes in synovial fluid</span></li> </ul>	
<input type="checkbox"/> <b>Thrombocytopenia:</b> Lowest platelet count _____	
<input type="checkbox"/> <b>Parotitis</b> (parotid gland swelling with pain and/or tenderness)	
<input type="checkbox"/> <b>Oculo-respiratory syndrome (ORS)</b> Bilateral red eyes AND at least one respiratory sign/symptom with or without facial edema, occurring within 24 hours of influenza vaccination	

**5. OTHER SEVERE OR UNUSUAL EVENT(S) NOT LISTED in 1-4 ABOVE** Complete temporal characteristics below and describe the event in the Supplementary Information section.

Temporal characteristics	Choose the single most appropriate period of time (either Min, Hrs, or Days) ☛ Time from immunization to 1st symptom/sign onset: __Min __Hrs __Days ☛ Time from onset of 1st symptom/sign to resolution of all symptoms/signs: __Min __Hrs __Days
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**SUPPLEMENTARY INFORMATION:**

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Please use additional pages if necessary