CASE REPORT FORM

Date of Visit	[//] (DD/MMM/YYYY)
Identifier	[//_] (Site ID/ Subject ID/ Subject Initial)
Date of Birth	[// (DD/MMM/YYYY)
Sex	☐ Male ☐ Female
	If Female, please check if applicable.
	☐ Pregnant ☐ Lactating
Recent	Please check all that apply
Vaccination	☐ Receive any vaccine within 4 weeks
History, etc.	☐ Plan to receive vaccine during 3 weeks
	☐ Received influenza vaccine in the past 6 months
	☐ Had influenza illness in the past 6 months
	□ Not applicable
Chronic illness	□ No □ Yes
	If Yes, please check all that apply
	☐ Diabetes
	☐ Hypertension
	☐ Heart disease
	☐ Cancer
	☐ Others, please specify
	(
Vital Sign/	Body Temperature [] (°C)
Physical	Height [] (cm)
Examination	Weight [] (kg)
	Blood Pressure [(systolic)/ (diastolic)] (mmHg)
	Body Temperature [] (°C)
Laboratory 1	Pregnancy test
	☐ Negative ☐ Positive
Laboratory 2	Hemagglutination Inhibition Test (HAI) of influenza antibodies
	[1:, or] (Unit: \[\text{Titers, or } \square \])
Laboratory 3	Sodium(Na): [](Unit: □mmol/L, or □) □Not done
(General	Potassium (K): [] (Unit: □mmol/L, or □) □Not done
	Glucose: [] (Unit: □mg/dl, or □) □Not done

laboratory	
tests)	
Post injection	□ No □ Yes
reaction	If Yes,
	1. Please specify the type of reaction
	☐ Solicited local reactions
	☐ Solicited systemic reactions
	☐ Unsolicited adverse events (AEs)
	☐ Unsolicited serious AEs (SAEs)
	2. Start and End Time of the reaction
	Start [:]- End [:] (HH: MM)
	3. Please describe the reaction, responses, and outcome in details
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