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| A description... | | | | | | | | | | |
| **ALBINISM SUPPORT PROGRAMME - REPORT SHEET** | | | | | | | | | | |
| **COUNTY:** | | | | | | | | | | |
|  | | | | | | | | | | |
| **NO.** | **DATE** | **NAME OF HEALTH FACILITY:**  **KOMBEWA COUNTY HOSPITAL** | **NO. OF PWAs MAPPED TO THE FACILITY** | **QUANTITIES BROUGHT FORWARD** | **DISPATCHED QUANTITIES BY KEMSA**  **MONTH:………..….….. YEAR:……….........……...** | **RECEIVED QUANTITIES BY THE FACILITY**  **MONTH:…………..….….. YEAR:………........………** | **NO. PWAs THAT HAVE RECEIVED LOTIONS**  **MONTH:…………..….….. YEAR:…..........………** | **NO. OF LOTIONS DISPENSED**  **MONTH:……………………………. YEAR:……………………………….** | | |
| **SUNSCREEN**  **LOTIONS** | **LIP BALM** | **AFTERSUN** |
| **1** |  |  |  |  |  |  |  |  |  |  |
| **2** |  |  |  |  |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |  |  |  |  |
| **8** |  |  |  |  |  |  |  |  |  |  |
| **9** |  |  |  |  |  |  |  |  |  |  |
| **10** |  |  |  |  |  |  |  |  |  |  |
| **11** |  |  |  |  |  |  |  |  |  |  |
| **12** |  |  |  |  |  |  |  |  |  |  |
| **13** |  |  |  |  |  |  |  |  |  |  |
| **14** |  |  |  |  |  |  |  |  |  |  |
| **15** |  |  |  |  |  |  |  |  |  |  |
| **TOTALS** | | |  |  |  |  |  |  |  |  |
| **Name of Disability Services Officer: ………………………………………………………………………………………………………………………………………… Designation: ………………………………………………………………………………………………………………………**  **Siganature: ………………………………………………………………………………………………………………………………………… Date: …………………………………………………………………………………………………………………………………**  **Stamp:**  **Note: Information collected on this data sheet should be onboarded on the Albinism MIS system and the form fowarded to HQ on a quartely basis. Attach copies of the bin cards and the dispensing registers.** | | | | | | | | | | |