



VACCINE ADVERSE EVENT REPORTING SYSTEM
24 Hour Toll-Free Information 1-800-822-7967
PATIENT IDENTITY KEPT CONFIDENTIAL

For CDC/FDA Use Only

VAERS Number

Date Received

Patient Name:

Last First M.I.

Address

City State Zip

Telephone no. ()

Vaccine administered by (Name):

Responsible Physician

Facility Name/Address

City State Zip

Telephone no. ()

Form completed by (Name):

Relation to Patient Vaccine Provider Patient/Parent Manufacturer Other

Address (if different from patient or provider)

City State Zip

Telephone no. ()

1. State 2. County where administered 3. Date of birth 4. Patient age 5. Sex 6. Date form completed

7. Describe adverse event(s) (symptoms, signs, time course) and treatment, if any. 8. Check all appropriate: Patient died, Life threatening illness, Required emergency room/doctor visit, Required hospitalization, Resulted in prolongation of hospitalization, Resulted in permanent disability, None of the above

9. Patient recovered YES NO UNKNOWN 10. Date of vaccination 11. Adverse event onset

12. Relevant diagnostic tests/laboratory data 13. Enter all vaccines given on date listed in no. 10

14. Any other vaccinations within 4 weeks prior to the date listed in no. 10

15. Vaccinated at: Private doctor's office/hospital, Military clinic/hospital, Public health clinic/hospital, Other/unknown. 16. Vaccine purchased with: Private funds, Military Funds, Public funds, Other/unknown. 17. Other medications

18. Illness at time of vaccination (specify) 19. Pre-existing physician-diagnosed allergies, birth defects, medical conditions (specify)

20. Have you reported this adverse event previously? No To health department To doctor To manufacturer. 22. Birth weight 23. No. of brothers and sisters

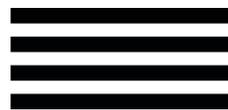
21. Adverse event following prior vaccination (check all applicable, specify) In patient In brother or sister. 24. Mfr./imm. proj. report no. 25. Date received by mfr./imm.proj. 26. 15 day report? 27. Report type



POSTAGE WILL BE PAID BY ADDRESSEE



NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES



VAERS
C/O DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION UNIT
MC1946
PO BOX 149347
AUSTIN TX 78714-9909



“Fold in thirds, tape & mail --- DO NOT STAPLE FORM”

DIRECTIONS FOR COMPLETING FORM

(Additional pages may be attached if more space is needed.)

GENERAL

- Use a separate form for each patient. Complete the form to the best of your abilities. Items 3, 4, 7, 8, 10, 11, and 13 are considered essential and should be completed whenever possible. Parents/Guardians may need to consult the facility where the vaccine was administered for some of the information (such as manufacturer, lot number or laboratory data.)
Refer to the Reportable Events Table (RET) for events mandated for reporting by law. Reporting for other serious events felt to be related but not on the RET is encouraged.
Health care providers other than the vaccine administrator (VA) treating a patient for a suspected adverse event should notify the VA and provide the information about the adverse event to allow the VA to complete the form to meet the VA's legal responsibility.
These data will be used to increase understanding of adverse events following vaccination and will become part of CDC Privacy Act System 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems". Information identifying the person who received the vaccine or that person's legal representative will not be made available to the public, but may be available to the vaccinee or legal representative.
Postage will be paid by addressee. Forms may be photocopied (must be front & back on same sheet).

SPECIFIC INSTRUCTIONS

Form Completed By: To be used by parents/guardians, vaccine manufacturers/distributors, vaccine administrators, and/or the person completing the form on behalf of the patient or the health professional who administered the vaccine.

- Item 7: Describe the suspected adverse event. Such things as temperature, local and general signs and symptoms, time course, duration of symptoms, diagnosis, treatment and recovery should be noted.
Item 9: Check "YES" if the patient's health condition is the same as it was prior to the vaccine, "NO" if the patient has not returned to the pre-vaccination state of health, or "UNKNOWN" if the patient's condition is not known.
Item 10: Give dates and times as specifically as you can remember. If you do not know the exact time, please
and 11: indicate "AM" or "PM" when possible if this information is known. If more than one adverse event, give the onset date and time for the most serious event.
Item 12: Include "negative" or "normal" results of any relevant tests performed as well as abnormal findings.
Item 13: List ONLY those vaccines given on the day listed in Item 10.
Item 14: List any other vaccines that the patient received within 4 weeks prior to the date listed in Item 10.
Item 16: This section refers to how the person who gave the vaccine purchased it, not to the patient's insurance.
Item 17: List any prescription or non-prescription medications the patient was taking when the vaccine(s) was given.
Item 18: List any short term illnesses the patient had on the date the vaccine(s) was given (i.e., cold, flu, ear infection).
Item 19: List any pre-existing physician-diagnosed allergies, birth defects, medical conditions (including developmental and/ or neurologic disorders) for the patient.
Item 21: List any suspected adverse events the patient, or the patient's brothers or sisters, may have had to previous vaccinations. If more than one brother or sister, or if the patient has reacted to more than one prior vaccine, use additional pages to explain completely. For the onset age of a patient, provide the age in months if less than two years old.
Item 26: This space is for manufacturers' use only.

