VACCINE ADVERSE EVENT REPORTING SYSTEM

P.O. Box 1100, Rockville, MD 20849-1100
24-Hour Toll Free Information Line **800-822-7967**
This VAERS Form can be faxed toll-free to **877-721-0366**
Web site: http://www.vaers.org **e-mail:** info@vaers.org

For VAERS Use ONLY

Box A: Patient Information

1. Patient's Last Name, First Name, M.I.
2. Parent/Guardian Name *(if patient is under 18 years)*
3. Patient's Telephone Number
4. Patient's Occupation *(if patient is age 18 or over)*
5. Patient's Current Address
6. City | State | Zip

Ò Date of Birth _____ / _____ / _____

Ó Age at vaccination

9. Weight at birth *(if under age 5)* lbs., oz.

10. Sex ☐ M ☐ F

11. Race/Ethnicity *(check all that apply)*
☐ White ☐ American Indian, Eskimo, or Aleut
☐ Black ☐ Asian or Pacific Islander
☐ Hispanic ☐ Other
(may be of any race)

Box B: Vaccine Provider Information

1. County where vaccine was administered:
2. Responsible Physician's Name:
3. Responsible Physician'sTelephone Number:
4 Responsible Physician's Facility Name:
5. Responsible Physician's Facility Street Address:
6. City | State | Zip

7. Vaccine was administered at:
☐ Physician's Office ☐ Military Facility
☐ Public Health Facility ☐ Workplace
☐ Hospital/Med. Center ☐ School/Daycare
☐ Other _____

8. Vaccine was purchased by provider with:
☐ Private Funds ☐ Other (please describe):
☐ Public Funds
☐ Military Funds

Box C: Reporter Information

1. Reporter is the person listed:
☐ In Box A ☐ In Box B ☐ Below
2. Reporter's Name
3. Reporter's Telephone Number:
4. Reporter's Facility/Organization Name
5. Reporter's Street Address
6. City | State | Zip

7. Date form completed: _____ / _____ / _____

8. Reporter's relationship to patient
☐ Family member ☐ Military Corpsman
☐ Nurse ☐ Pharmacist
☐ Physicians' Assistant
☐ Other Reporter (please describe below):

Box D: Vaccination Information

Provide information for all vaccines given on this date:	Vaccine Name	Manufacturer	Lot Number	Vaccination Route	Vaccination Site	Dose # in Series
Date of vaccination _____ / _____ / _____	a.					
	b.					
Time of vaccination _____ ☐ AM	c.					
	d.					
_____ ☐ PM	e.					

Box E: Adverse Event Information

Describe the signs and symptoms that occurred after this vaccination and treatment, if any.
(Attach additional sheets if necessary)

DRAFT ***NOT TO BE USED FOR REPORTING!***

How soon after vaccination did these event(s) start? *(check units)*
_____ ☐ Hours ☐ Weeks ☐ Days ☐ Months

Did this event cause the patient to visit the doctor?
☐ No ☐ Yes If Yes, date of visit: _____ / _____ / _____

6. Has the patient recovered to his/her original state of health?
☐ Yes ☐ Not Yet ☐ No ☐ Unknown

Date of onset: _____ / _____ / _____

5. List results of relevant diagnostic procedures or lab testing:

Check below if the patient:
☐ Died
Date: _____ / _____ / _____
☐ Had life-threatening event
List event:
☐ Was hospitalized after vaccination
Date admitted: _____ / _____ / _____
☐ Was already hospitalized and his/her stay was prolonged by _____ days
☐ Experienced permanent disability
List disability:
☐ Required medical intervention to prevent any of the above outcomes.
☐ Experienced none of the above

Box F: Patient's Prior Health History

1. List recipient's pre-existing physician-diagnosed illnesses, allergies, and/or medical conditions.
2. List any acute illnesses the recipient was experiencing at the time of the vaccination(s) given in Box D.
3. List any medications the recipient was receiving at the time of the vaccination(s) given in Box D.

List any other vaccines administered to the recipient within 4 weeks of the date given in Box D above:

	4. Date vaccine given	5. Vaccine Name	6. Manufacturer	7. Lot Number	Vaccination 8. Route	Vaccination 9. Site	10. Dose # in Series
a.							
b.							

Box G: For Secondary Reporters' Use Only

1. Secondary reporter type
☐ Vaccine Manufacturer FDA Lic. # _____
☐ State Immunization Coord. State _____
☐ Immunization Registry
Name: _____

2. Tracking Number

3. Date received

4. Type of secondary report
☐ Initial ☐ Follow-up ☐ Mfrs. 15-day

5. Does this report qualify as OMIC?
☐ Yes ☐ No

Form VAERS-2
(revised Jul 2001)

Healthcare providers and manufacturers are required by law (42 USC 300aa-25) to report reactions to vaccines listed in the *Reportable Events Table* following immunization. Reports for reactions to other vaccines are voluntary except when required as a condition of the immunization grant awards.