VAERS

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BUSINESS REPLY MAIL

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POSTAGE WILL BE PAID BY ADDRESSEE

VAERS
PO Box 1100
Rockville, MD 20849-1100

DIRECTIONS FOR COMPLETING THIS FORM

General Information

- This information will be used to increase understanding of adverse events following vaccination**. You may be contacted by the officials from the Centers for Disease Control and Prevention, Food and Drug Administration or VAERS if the information you provide is incomplete, illegible or unclear.**
- Information in Box A1- A6 is used to identify the person who received the vaccine (or that person's legal representative) and will not be made available to the public. However, it may be made available to the vaccinee or their legal representative.
- Items numbered in white inside of black circles (Box A6 and A7, all of Box D, Box E1, E2, E3, E4 and E7) are considered essential epidemiological information and are to be completed whenever possible.
- Parents/Guardians may need to consult the healthcare provider administering the vaccine in order to complete some of the information on this form (particularly the information in Box D).
- Report all adverse events temporally associated with the vaccination, even if you are not sure they are related.
- Healthcare providers and vaccine manufacturers are required to report events listed in the most recent version of the Reportable Events Table (RET-see www.vaers.org). Reporting other serious events felt to be related to the vaccine—but which are not on the RET—is encouraged.
- Healthcare providers other than the one administering the vaccine should notify the vaccine administrator if an adverse event is suspected so that the provider administering the vaccine can fulfill their legal responsibility.
- If you fold this form in thirds, tape the open edges, and mail it though the US Postal Service, the postage will be paid by VAERS.
- Forms may be photocopied or obtained from the VAERS office or Web site (www.Vaers.org)

Specific Instructions

Use a separate form for each vaccine recipient and each vaccination that was given on a different date. Complete the form to the best of your ability. For more detailed instructions, see www.vaers.org or call 800-822-7967.

Item A7: Provide the patient's age ***at the time of vaccination*** (not age when the form was completed).
Item B8: Indicate funding the healthcare provider used to purchase the vaccine(s), not the vaccinee's insurance.
Item C1: If the person completing the form already provided contact information in either Box A or Box B, this information does not need to be provided again in Box C. Other reporters should provide contact information for Items C2-C8.
Item C7: Provide the date the from was completed
Item C8: The Box C reporter should indicate their relationship to the patient (e.g., person administering the vaccine, pharmacist, grandparent, neighbor, friend, etc.).
Item D1: Provide the date the vaccination(s) associated with the reported event(s) was administered.
Item D2: Provide the time the vaccine was administered. If you do not know the exact time, note the approximate time or check the "AM" or "PM" boxes
Item D3 thru D5: List only the vaccines that were given on the date in Item D1. Provide as much information about the vaccine as possible. Use additional sheets if more than five vaccines were administered at once
Item D6 Provide the route of administration (e.g., SC, IM)
Item D7: Provide the site of administration (e.g., right arm, left thigh).
Item D8: If the listed vaccine is part of a series, provide the dose number in the series (e.g., dose 2 of 3).
Item E1: Describe the suspected adverse event. Provide information such as the vaccinee's temperature, local and general signs and symptoms, time course, duration of symptoms, diagnosis, and treatment. Use additional sheets as necessary.
Item E2: Indicate the time interval after vaccination in which the adverse event occurred. Specify the unit of time (hours, days, weeks or months).
Item E3: Indicate if the vaccinee sought medical treatment from a healthcare provider or the emergency room.
Item E5: Include "negative" or "normal" results of any relevant tests as well as abnormal findings.
Item E6: Check "YES" if the vaccinee's health condition has returned to what it was prior to the vaccination; "Not yet" if the vaccinee is still recovering from the adverse event; "NO" if the vaccinee is not likely to returned to the pre-vaccination state of health; or "UNKNOWN" if the vaccinee's condition is not known.
Item E8: Check any of the events that occurred and provide the requested information for the checked event.
Item F1: List the vaccinee's chronic or pre-existing physician-diagnosed illnesses, allergies, birth defects, and/or medical conditions (including developmental and/or neurological disorders).
Item F2: List any short-term or acute illnesses the vaccinee was experiencing at the time of vaccination (e.g., cold, flu)
Item F3: List any prescription or non-prescription medications the vaccinee was taking at the time of vaccination.