



**Missouri Department of Health and Senior Services**  
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**Maureen E. Dempsey, M.D.**  
Director



**Bob Holden**  
Governor

November 28, 2001

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DOCKETS MANAGEMENT BRANCH (HFA-305)  
FOOD AND DRUG ADMINISTRATION  
5630 FISHERS LN, RM 1061  
ROCKVILLE MD 20852

Docket Number: 01N-0464

To Whom It May Concern:

This is in response to your request to review the draft copy of docket number 01N-0464 (VAERS) and to submit opinions.

After reviewing the draft copy, the only main problem I can see, is the size of the areas you want information entered into. I know, that with the form that is still being used, there seems to be a problem with entering information needed into small areas. Also, the lay out seemed to cause areas to be left blank. With the layout and size of the draft copy I believe there will be more missed information.

Another problem with the draft copy of docket number 01N-0464 is the font. We have a visually impaired person working in my area. I asked her to look at the draft copy and give me her opinion. The first problem she noticed was the small font. Secondly, there was too much black area. The combination of the two made it more difficult for her to read. Granted, there will not be anyone with as severe vision problem filling out these forms, but even with corrective lenses, it may be difficult for someone to read and fill out properly

I have enclosed a very rough idea of a layout that might work best for a new VAERS forms.

Sincerely,

Lora Cable  
Clerk Typist III  
Section of Vaccine-Preventable  
and Tuberculosis Disease Elimination

01N-0464

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[www.dhss.state.mo.us](http://www.dhss.state.mo.us)

The Missouri Department of Health and Senior Services enhances quality of life for all Missourians by protecting and promoting the community's health and the well-being of citizens of all ages.

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER. Services provided on a nondiscriminatory basis.

**VACCINE ADVERSE EVENT**

PO Box 1100, Rockville  
24-Hour Toll Free Informat  
This VAERS Form can be faxed

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
Last First MI

D.O.B.: \_\_\_\_\_ Sex:    M    F  
Mon./Day/Yr.

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Age at vaccination: \_\_\_\_\_

Wt. at Birth (if under age 5) \_\_\_\_\_ lb. \_\_\_\_\_ o.z.

Race/Ethnicity (Check all that apply)

   White    Other \_\_\_\_\_

   Black    Hispanic

   Asian or Pacific Islander

   American Indian, Eskimo, or Aleut

Parent/Guardian Name (if patient is under 18 years)  
\_\_\_\_\_

**PATIENT'S PRIOR HEALTH HISTORY**

List pre-existing medical conditions:  
\_\_\_\_\_  
\_\_\_\_\_

List acute illnesses at time of vaccination(s)  
\_\_\_\_\_  
\_\_\_\_\_

List medications taken at time of vaccination(s)  
\_\_\_\_\_  
\_\_\_\_\_

List vaccine(s) administered within 4 weeks of date of vaccination(s). Include: date, vaccine name, manufacturer and lot number.  
\_\_\_\_\_  
\_\_\_\_\_

**VACCINE WAS ADMINISTERED AT**

   Physician's Office    Military Facility  
   Public Health Facility    Workplace  
   Hospital/Med. Center    School/Daycare  
   Other \_\_\_\_\_

3. Date of vaccination \_\_\_\_\_

Time \_\_\_\_\_

Vaccine Name \_\_\_\_\_

Manufacturer \_\_\_\_\_

Lot # \_\_\_\_\_

Route/Site \_\_\_\_\_

Dose # in series \_\_\_\_\_

4. Date of vaccination \_\_\_\_\_

Time \_\_\_\_\_

Vaccine Name \_\_\_\_\_

Manufacturer \_\_\_\_\_

Lot # \_\_\_\_\_

Route/Site \_\_\_\_\_

Dose # in series \_\_\_\_\_

5. Date of vaccination \_\_\_\_\_

Time \_\_\_\_\_

Vaccine Name \_\_\_\_\_

Manufacturer \_\_\_\_\_

Lot # \_\_\_\_\_

Route/Site \_\_\_\_\_

Dose # in series \_\_\_\_\_

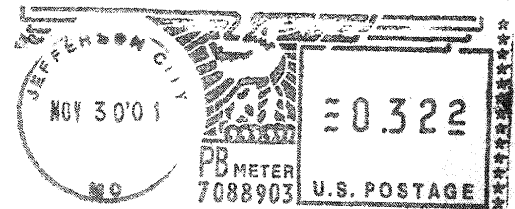
STATE OF MISSOURI  
DEPARTMENT OF HEALTH  
P.O. BOX 570  
JEFFERSON CITY, MISSOURI 65102-0570

MO 580-0160 (10-97)

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FOOD AND DRUG ADMINISTRATION  
5630 FISHERS LN, RM 1061  
ROCKVILLE MD 20852

*Docket No: 01N-0464*

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