WEBSITE: www.vaers.org E-MAIL: info@vaers.org FAX: 1-877-721-0366

VAERS

VACCINE ADVERSE EVENT REPORTING SYSTEM

24 Hour Toll-Free Information 1-800-822-7967
P.O. Box 1100, Rockville, MD 20849-1100
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 ___/___/___ (mm dd yy)
4. Patient age
5. Sex ☐ M ☐ F
6. Date form completed ___/___/___ (mm dd yy)

7. Describe adverse events(s) (symptoms, signs, time course) and treatment, if any

8. Check all appropriate:
☐ Patient died (date ___/___/___ (mm dd yy))
☐ Life threatening illness
☐ Required emergency room/doctor visit
☐ Required hospitalization (_____days)
☐ Resulted in prolongation of hospitalization
☐ Resulted in permanent disability
☐ None of the above

9. Patient recovered ☐ YES ☐ NO ☐ UNKNOWN

10. Date of vaccination ___/___/___ (mm dd yy) Time _____ AM PM

11. Adverse event onset ___/___/___ (mm dd yy) Time _____ AM PM

12. Relevant diagnostic tests/laboratory data

13. Enter all vaccines given on date listed in no. 10

	Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous Doses
a.					
b.					
c.					
d.					

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

	Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous doses	Date given
a.						
b.						

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

Only for children 5 and under

22. Birth weight _____ lb. _____ oz.

23. No. of brothers and sisters

21. Adverse event following prior vaccination (check all applicable, specify)

	Adverse Event	Onset Age	Type Vaccine	Dose no. in series
☐ In patient				
☐ In brother or sister				

Only for reports submitted by manufacturer/immunization project

24. Mfr./imm. proj. report no.

25. Date received by mfr./imm.proj.

26. 15 day report? ☐ Yes ☐ No

27. Report type ☐ Initial ☐ Follow-Up

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