



**INFORMATION ABOUT THE PATIENT WHO RECEIVED THE VACCINE (Use Continuation Page if needed)**

<p>1. Patient name: (first) _____ (last) _____          Street address: _____          City: _____ State: _____ County: _____          ZIP code: _____ Phone: _____ Email: _____</p>	<p>9. Prescriptions, over-the-counter medications, dietary supplements, or herbal remedies being taken at the time of vaccination: _____</p>
<p>2. Date of birth: (mm/dd/yyyy) _____  3. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown</p>	<p>10. Allergies to medications, food, or other products: _____</p>
<p>4. Date and time of vaccination: (mm/dd/yyyy) _____  Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM</p>	<p>11. Other illnesses at the time of vaccination and up to one month prior: _____</p>
<p>5. Date and time adverse event started: (mm/dd/yyyy) _____  Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM</p>	<p>12. Chronic or long-standing health conditions: _____</p>
<p>6. Age at vaccination: _____ Years _____ Months 7. Today's date: (mm/dd/yyyy) _____ </p>	
<p>8. Pregnant at time of vaccination?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown          (If yes, describe the event, any pregnancy complications, and estimated due date if known in item 18)</p>	

**INFORMATION ABOUT THE PERSON COMPLETING THIS FORM**

**INFORMATION ABOUT THE FACILITY WHERE VACCINE WAS GIVEN**

<p>13. Form completed by: (name) _____          Relation to patient: <input type="checkbox"/> Healthcare professional/staff <input type="checkbox"/> Patient (yourself)  <input type="checkbox"/> Parent/guardian/caregiver <input type="checkbox"/> Other: _____          Street address: _____ <input type="checkbox"/> Check if same as item 1          City: _____ State: _____ ZIP code: _____          Phone: _____ Email: _____</p>	<p>15. Facility/clinic name: _____          Fax: _____          Street address: _____ <input type="checkbox"/> Check if same as item 13          City: _____          State: _____ ZIP code: _____          Phone: _____</p>
<p>14. Best doctor/healthcare professional to contact about the adverse event:          Name: _____          Phone: _____ Ext: _____</p>	<p>16. Type of facility: (Check one)  <input type="checkbox"/> Doctor's office, urgent care, or hospital  <input type="checkbox"/> Pharmacy or store  <input type="checkbox"/> Workplace clinic  <input type="checkbox"/> Public health clinic  <input type="checkbox"/> Nursing home or senior living facility  <input type="checkbox"/> School or student health clinic  <input type="checkbox"/> Other: _____  <input type="checkbox"/> Unknown</p>

**WHICH VACCINES WERE GIVEN? WHAT HAPPENED TO THE PATIENT?**

<p>17. Enter all vaccines given on the date listed in item 4: (Route is HOW vaccine was given, Body site is WHERE vaccine was given) Use <b>Continuation Page</b> if needed</p>						Dose number in series
Vaccine (type and brand name)	Manufacturer	Lot number	Route	Body site		
<p>18. Describe the adverse event(s), treatment, and outcome(s), if any: (symptoms, signs, time course, etc.)           Use <b>Continuation Page</b> if needed</p>						<p>21. Result or outcome of adverse event(s): (Check all that apply)  <input type="checkbox"/> Doctor or other healthcare professional office/clinic visit  <input type="checkbox"/> Emergency room/department or urgent care  <input type="checkbox"/> Hospitalization: Number of days (if known) _____          Hospital name: _____          City: _____ State: _____  <input type="checkbox"/> Prolongation of existing hospitalization (vaccine received during existing hospitalization)  <input type="checkbox"/> Life threatening illness (immediate risk of death from the event)  <input type="checkbox"/> Disability or permanent damage  <input type="checkbox"/> Patient died – Date of death: (mm/dd/yyyy) _____   <input type="checkbox"/> Congenital anomaly or birth defect  <input type="checkbox"/> None of the above</p>
<p>19. Medical tests and laboratory results related to the adverse event(s): (include dates)           Use <b>Continuation Page</b> if needed</p>						
<p>20. Has the patient recovered from the adverse event(s)?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>						

**ADDITIONAL INFORMATION**

<p>22. Any other vaccines received within one month prior to the date listed in item 4: Use <b>Continuation Page</b> if needed</p>						Dose number in series	Date Given
Vaccine (type and brand name)	Manufacturer	Lot number	Route	Body site			
<p>23. Has the patient ever had an adverse event following any previous vaccine?: (If yes, describe adverse event, patient age at vaccination, vaccination dates, vaccine type, and brand name)  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>							
<p>24. Patient's race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander  <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____</p>							
<p>25. Patient's ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown</p>				<p>26. Immuniz. proj. report number: (Health Dept use only) _____</p>			

**COMPLETE ONLY FOR U.S. MILITARY/DEPARTMENT OF DEFENSE (DoD) RELATED REPORTS**

<p>27. Status at vaccination: <input type="checkbox"/> Active duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard <input type="checkbox"/> Beneficiary <input type="checkbox"/> Other: _____</p>	<p>28. Vaccinated at Military/DoD site: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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17. Enter all vaccines given on the date listed in item 4 (continued):					Dose number in series
Vaccine (type and brand name)	Manufacturer	Lot number	Route	Body site	

22. Any other vaccines received within one month prior to the date listed in item 4 (continued):					Dose number in series	Date Given
Vaccine (type and brand name)	Manufacturer	Lot number	Route	Body site		

Use the space below to provide any additional information (indicate item number):

# COMPLETING THE VACCINE ADVERSE EVENT REPORTING SYSTEM (VAERS) FORM

## GENERAL INSTRUCTIONS

- Submit this form electronically using the Internet. For instructions, visit [www.vaers.hhs.gov/uploadfile/](http://www.vaers.hhs.gov/uploadfile/).
- If you are unable to submit this form electronically, you may fax it to VAERS at 1-877-721-0366.
- If you need additional help submitting a report you may call the VAERS toll-free information line at 1-800-822-7967, or send an email to [info@vaers.org](mailto:info@vaers.org).
- Fill out the VAERS form as completely as possible and use the **Continuation Page** if needed. Use a separate VAERS form for each individual patient.
- If you do not know exact numbers, dates, or times, please provide your best guess. You may leave these spaces blank if you are not comfortable guessing.
- You can get specific information on the vaccine and vaccine lot number by contacting the facility or clinic where the vaccine was administered.
- Please report all significant adverse events that occur after vaccination of adults and children, even if you are not sure whether the vaccine caused the adverse event.
- Healthcare professionals should refer to the VAERS Table of Reportable Events at [www.vaers.hhs.gov/reportable.html](http://www.vaers.hhs.gov/reportable.html) for the list of adverse events that must be reported by law (42 USC 300aa-25).
- Healthcare professionals treating a patient for a suspected vaccine adverse event may need to contact the person who administered the vaccine in order to exchange information and decide how best to complete and submit the VAERS form.

## SPECIFIC INSTRUCTIONS

**Items 2, 3, 4, 5, 6, 17, 18 and 21** are **ESSENTIAL** and should be completed.

- **Items 4 and 5:** Provide dates and times as specifically as you can and enter as much information as possible (e.g., enter the month and year even if you don't know the day). If you do not know the exact time, but know it was in the morning ("AM") or afternoon or evening ("PM"), please provide that information.
- **Item 6:** If you fill in the form by hand, provide age in years. If a child is less than 1 year old, provide months of age. If a child is more than 1 year old but less than 2 years old, provide year and months (e.g., 1 year and 6 months). If a child is less than 1 month of age when vaccinated (e.g., a birth dose of hepatitis B vaccine) then answer 0 years and 0 months, but be sure to include the patient's date of birth (item 2) and date and time of vaccination (item 4).
- **Item 8:** If the patient who received the vaccine was pregnant at time of vaccination, select "Yes" and describe the event, any pregnancy complications, and estimated due date if known in item 18. Otherwise, select "No" or "Unknown."
- **Item 9:** List any prescriptions, over-the-counter medications, dietary supplements, herbal remedies, or other non-traditional/alternative medicines being taken by the patient when the vaccine(s) was given.
- **Item 10:** List any allergies the patient has to medications, foods, or other products.
- **Item 11:** List any short-term or acute illnesses the patient had on the date of vaccination AND up to one month prior to this date (e.g., cold, stomach flu, ear infection, etc.). This does **NOT** include the adverse event you are reporting.
- **Item 12:** List any chronic or long-standing health conditions the patient has (e.g., asthma, diabetes, heart disease).
- **Item 13:** List the name of the person who is completing the form. Select the "Check if same as item 1" box if you are the patient or if you live at the same address as the patient. The contact information you provided in item 1 will be automatically entered for you. Otherwise, please provide new contact information.
- **Item 14:** List the doctor or other healthcare professional who is the best person to contact to discuss the clinical details of the adverse event.
- **Item 15:** Select the "Check if same as item 13" box if the person completing the form works at the facility that administered the vaccine(s). The contact information provided in item 13 will be automatically entered for you. Otherwise, provide new contact information.
- **Item 16:** Select the option that best describes the type of facility where the vaccine(s) was given.

- **Item 17:** Include only vaccines given on the date provided in item 4. The vaccine route options include:
  - Injection/shot (intramuscular, subcutaneous, intradermal, jet injection, and unknown)
  - By mouth/oral
  - Other (specify)
  - In nose/intranasal
  - Unknown

For body site, the options include:

- Right arm
- Left arm
- Arm (side unknown)
- Right thigh
- Left thigh
- Thigh (side unknown)
- Nose
- Mouth
- Other (specify)
- Unknown

For vaccines given as a series (i.e., 2 or more doses of the same vaccine given to complete a series), list the dose number for the vaccine in the last column named "Dose number in series."

- **Item 18:** Describe the adverse event(s), treatment, and outcome(s). Include signs and symptoms, when the symptoms occurred, diagnosis, and treatment. Provide specific information if you can (e.g., if patient had a fever, provide the temperature).
- **Item 19:** List any medical tests and laboratory results related to the adverse event(s). Include abnormal findings as well as normal or negative findings.
- **Item 20:** Select "Yes" if the patient's health is the same as it was prior to the vaccination or "No" if the patient has not returned to the same state of health prior to the vaccination, and provide details in item 18. Select "Unknown" if the patient's present condition is not known.
- **Item 21:** Select the result(s) or outcome(s) for the patient. If the patient did not have any of the outcomes listed, select "None of the above." Prolongation of existing hospitalization means the patient received a vaccine during a hospital stay and an adverse event following vaccination occurred that resulted in the patient spending extra time in the hospital. Life threatening illness means you believe this adverse event could have resulted in the death of the patient.
- **Item 22:** List any other vaccines the patient received within one month prior to the vaccination date listed in item 4.
- **Item 23:** Describe the adverse event(s) following any previous vaccine(s). Include patient age at vaccination, dates of vaccination, vaccine type, and brand name.
- **Item 24:** Check all races that apply.
- **Item 25:** Check the single best answer for ethnicity.
- **Item 26:** For health department use only.
- **Items 27 and 28:** Complete only for U.S. Military or Department of Defense related reports. In addition to active duty service members, Reserve and National Guard members, beneficiaries include: retirees, their families, survivors, certain former spouses, and others who are registered in the Defense Enrollment Eligibility Reporting System (DEERS).

## GENERAL INFORMATION

- VAERS ([www.vaers.hhs.gov](http://www.vaers.hhs.gov)) is a national vaccine safety monitoring system that collects information about adverse events (possible reactions or problems) that occur during or after administration of vaccines licensed in the United States.
- VAERS protects patient identity and keeps patient identifying information confidential.
- The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule permits reporting of protected health information to public health authorities including the Centers for Disease Control and Prevention (CDC) and U.S. Food and Drug Administration (FDA) (45 CFR § 164.512(b)).
- VAERS accepts all reports without judging the importance of the adverse event or whether a vaccine caused the adverse event.
- Acceptance of a VAERS report by CDC and FDA does not constitute admission that the vaccine or healthcare personnel caused or contributed to the reported event.
- The National Vaccine Injury Compensation Program (VICP) is administered by the Health Resources and Services Administration (HRSA). The VICP is separate from the VAERS program and reporting an event to VAERS does not constitute filing a claim for compensation to the VICP (see [www.hrsa.gov/vaccinecompensation/index.html](http://www.hrsa.gov/vaccinecompensation/index.html)).
- Knowingly filing a false VAERS report with the intent to mislead the Department of Health and Human Services is a violation of Federal law (18 U.S. Code § 1001) punishable by fine and imprisonment.