

Vaccine Adverse Event Reporting System (VAERS)

Online Reporting
January 23, 2003

Please read the instructions before you fill-out the VAERS form

VACCINE ADVERSE EVENT REPORTING SYSTEM

24 Hour Toll-free information line: 1-800-822-7967

Fax number: 1-877-721-0366

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: MI:

Address:

City:

State: ZIP: -

Phone No: () -

Vaccine Administered by (Name):

Last:
 First: MI:

Responsible Physician (Name):

Last:
 First: MI:

Facility Name:

Facility Address:

City:

Form completed by (Name):

Last:
 First: MI:

Relation to Patient

Address (if different from patient or

City:

State: ZIP: -

Phone No: () -

1. State 2. County or Country where administered
3. Date of Birth
(mm / dd / yyyy) / /

4. Patient Age at Vaccination

 yr. mo.5. Sex 6. Date form Completed
(mm / dd / yyyy) / / 7. Describe adverse event(s) (symptoms, signs, time course) and treatment, if any

8. Check all appropriate:

- Patient Died (date / /) (mm. / dd. / yyyy)
- 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: 12. Relevant diagnostic tests/laboratory data:10. Date of vaccination:

Date: (mm / dd / yyyy)

 / / Time: : AM PM11. Adverse event onset:

Date: (mm / dd / yyyy)

 / / Time: : AM PM13. Enter all vaccines given on date listed in no. 10

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

Vaccine	Manufacturer	Lot Number	Route	Site	No of Previous Doses
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="button" value="Add 4 More"/>					

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

Vaccine	Manufacturer	Lot Number	Route	Site	No of Previous Doses	D. (mm / d)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>
<input type="button" value="Add 4 More"/>						

15. Vaccinated at: 16. Vaccine purchased with: 17. Other medications

12. Relevant diagnostic tests/laboratory data:

Date: (mm / dd / yyyy)

/ /

Time: :

AM PM

onset:

Date: (mm / dd / yyyy)

/ /

Time: :

AM PM

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

Vaccine	Manufacturer	Lot Number	Route	Site	No of Previous Doses
Smallpox (DnvaX)	Wyeth Laboratories, Inc				
Add 4 More					

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

Vaccine	Manufacturer	Lot Number	Route	Site	No of Previous Doses	Date (mm / dd / yyyy)



PVN Entry Form - Microsoft Internet Explorer pro...



Please enter the vaccinee's PVN (Patient Vaccination Number). If a PVN was not provided, then select "Alternate Number" and enter the alternate vaccination number provided, or select "No Number Available" if a PVN or alternate was not provided or is unknown at this time.



PVN



Alternate Number



No Number Available

PVN: PVN

Save

Cancel

18. Illness at time of vaccination

19. Pre-existing physician-diagnosed allergies, birth medical conditions (specify)

20. Have you reported this 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 that apply, specify:

Relationship	Adverse Event	Onset Age		Vaccine	Manufacturer	Dose no. in series
		Yr	Mo			
In Patient	<input type="text"/>					
In Brother or Sister	<input type="text"/>					
In Brother or Sister	<input type="text"/>					



File Edit View Favorites Tools Help



Back Forward Stop Home Search Favorites Media Print Print Preview Print Settings

Address https://stc-vaers.asciences.com/VaersDataEntry.cfm



Links >>

Only for reports submitted by manufacturer/immunization project

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

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

 / / (mm / dd / yyyy)

26. 15 day report

27. Report Type

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

(Press once only!)

Print E-Report and Confirmation for Your Records

VACCINE ADVERSE EVENT REPORTING SYSTEM

(VAERS)

**Thank you for using the VAERS on-line reporting system.
Your report was submitted:**

01/18/2003

**Your on-line VAERS E-Report Number is:
E - 15592**

Patient identity is confidential.

**If you have any questions about this report or VAERS,
please contact us at:**

Toll-free information line: 1-800-822-7967
Fax number: 1-877-721-0366
E-mail: info@vaers.org
 or
Mail us at:
P.O. Box 1100
Rockville, MD 20849-1100

[Home](#)

<p>VACCINE ADVERSE EVENT REPORTING SYSTEM 24 Hour Toll-free information line: 1-800-822-7967 Fax number: 1-877-721-0366 P.O. Box 1100, Rockville, MD 20849-1100 PATIENT IDENTITY KEPT CONFIDENTIAL</p>	<p>For CDC/FDA Use Only VAERS Number: Date Received:</p>
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<p>Patient Name: Last: First: MI:</p>	<p>Vaccine Administered by (Name): Last: First: MI:</p>	<p>Form completed by (Name): Last: First: MI:</p>
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7. Describe adverse event(s) (symptoms, signs, time course) and treatment, if any

This is a test, only, just for demonstration purposes for a presentation to our state and local partners.

8. Check all appropriate:

9. Patient recovered:

12. Relevant diagnostic tests/laboratory data:

10. Date of vaccination:
Date: //
Time: :

11. Adverse event onset:
Date: //
Time: :

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

Vaccine	Manufacturer	Lot Number	Route	Site	No. of Previous Doses
Smallpox (Dryvax)	Wyeth Laboratories, Inc				

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

Vaccine	Manufacturer	Lot Number	Route	Site	No. of Previous Doses	Date

15. Vaccinated at:

16. Vaccine purchased with:

17. Other medications

18. Illness at time of vaccination

19. Pre-existing physician-diagnosed allergies, birth defects, medical conditions (specify)

21. Adverse event following prior vaccination. Check all that apply, specify:

Relationship	Adverse Event	Onset Age		Vaccine	Manufacturer	Dose no. in series
		Yr	Mo			
In Patient						
In Brother or Sister						
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	27. Report Type Initial

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.

Print E-Report and Confirmation for Your Records

Queries

Submission of Supporting Documents for VAERS Reports

- Examples: medical records or other clinical documentation
- Submit initial report electronically, then fax or mail supporting documents noting VAERS E-Report number, PVN or the unique vaccination number in the upper right hand corner of each page or on a fax cover sheet.
- Cut & paste electronic information into Box 7, 12, 17, 18, and/or 19