The VAERS Project

Making a VAERS Report

Who: Patients, caregivers, and healthcare professionals.

When: When adverse events (AE) are suspected. Consider reporting non-routine appointments after vaccination.

Why: To satisfy the request of CDC/FDA, legal requirements, and to ensure highest level of vaccine safety.

What: Any clinically significant adverse event occurring after vaccination.

How: Gather needed information, visit **VAERS.HHS.GOV,** and use the online tool or downloading the writable PDF.

Gather Information

Required Fields:

Patient Date of Birth: ___________________ **Patient Sex:** ❑ Male ❑ Female ❑ Unknown

Date & Time of Vaccination: ____________________

Date & Time AE Started: ____________________

Age at Vaccination: ____________________

(list age in months if under two years)

If unknown provide best guess. Time may simply be AM or PM.

List All Vaccinations Given (Route is HOW vaccine was given, Body site is WHERE vaccine was given)

Vaccine (Type/Brand Name)	Manufacturer	Lot Number	Route	Body site	Dose # in series

Describe the adverse event(s), treatment, and outcome(s), if any: (symptoms, signs, time, course, etc. If using the online form, you may be able to copy and paste details from the electronic record)

Result or outcome of adverse event(s): (Check all that apply)

❑Doctor or other healthcare professional office/clinic visit

❑ Emergency room/department or urgent care visit

❑ Hospitalization: Number of days (if known) _____

Hospital name: ______________________________

City: _____________________ State: ________

❑ Prolongation of existing hospitalization (vaccine received during existing hospitalization)

❑ Life threatening illness (immediate risk of death from the event)

❑ Disability or permanent damage

❑ Patient died – Date of death: ______________

❑ Congenital anomaly or birth defect

❑None of the above

Additional Fields:

Many of these fields can be copied directly into the VAERS report from the electronic record.

About the Patient:

❑ Street Address

❑ Phone

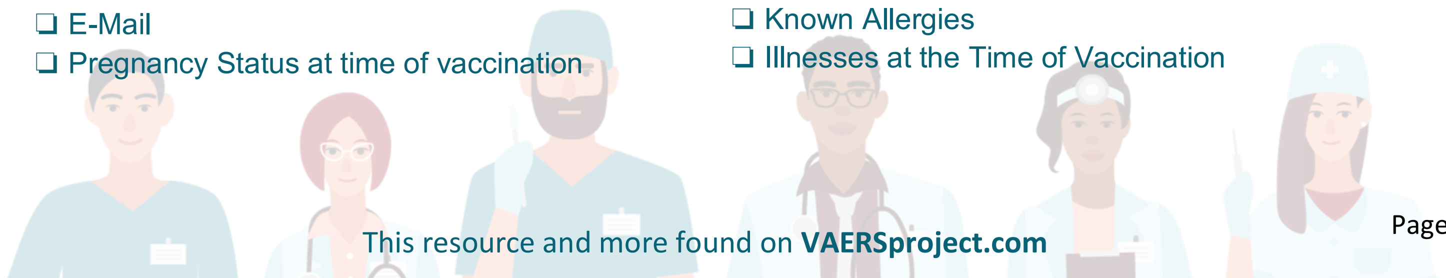
❑ E-Mail

❑ Pregnancy Status at time of vaccination

❑ Prescriptions, OTC, Supplements, Herbs at the time of vaccination

❑ Known Allergies

❑ Illnesses at the Time of Vaccination



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About the Person Completing the Form:

- ❏ Name
- ❏ Relation to the Patient
- ❏ Street Address
- ❏ Phone
- ❏ E-Mail
- ❏ Name & Phone of the Best Doctor/Healthcare Professional to Contact About the AE.

Information About the Facility Where The Vaccine was Given:

- ❏ Facility/Clinic Name
- ❏ Fax
- ❏ Street Address
- ❏ Phone
- ❏ Type of Facility

Additional Information

Any Other Vaccinations Given Within One Month:

Vaccine (Type/Brand Name)	Manufacturer	Lot Number	Route	Body site	Dose # in series

❏ Has the Patient Ever had an AE Following Any Previous Vaccines?
(If yes, describe AE, Pt Age at vaccination, Vaccination Date, Type & Brand Name.)

❏ Patient's Race

After the Report is Completed

- ❏ Report Confirmation Number: ______________________________________
- ❏ A Copy of the Report & Confirmation Number Placed on the Patient's Permanent Record
- ❏ The Patient has been Educated:
  - ❏ On VAERS & the Report
  - ❏ On VICP/CICP as Appropriate
  - ❏ Only One Report Should be Made
  - ❏ To Notify Other Providers & to Add a Copy of the Report to Their Permanent Record

Notes

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