Health

Santé

In confidence to: Vaccine Adverse Events Surveillance

REPORT OF A VACC ADVERSE EVENT	Protected when a				Winnipeg, Ma Fax: 948-2040			
DENTIFICATION OF PATIENT  AME		DATE OF BIRTH ADMINISTRA			DATE OF VACCINE ADMINISTRATION  OR MONTH DA			
C. C.	DDRESS (NO., STRE	, 0111)				Male Female		
ACCINES								
VACCINE(S) GIVEN NUMBER IN SERIES		SITE	ROUTE	DOSAGE	MANUFACTURER		LOT NUMBER	
DVERSE EVENT(S) Events marking conditio	ked with an asteris	sk (*) must be dia prmation for all e	agnosed by a vents should	<u>physician.</u> Report be provided under	only events which SUPPLEMENTAR	cannot be at	tributed to co-ex ON on reverse s	
Record inte CAL REACTION AT INJECTION SITE	rval between vacc	ine administratio	CONTRACTOR DESCRIPTION	of each event in mi VERE VOMITING AND		ays.	MIN. HOURS	
INFECTED ABSCESS (tick one or both of the	he options below)	MIN. HOURS	Drill C	st be severe enough to				
(i) positive gram stain or culture (ii) existence of purulent discharge with infla		Cha of m	HYPOTONIC-HYPORESPONSIVE EPISODE (in children < 2 yrs, only Characterised by <u>all the features</u> of: (i) generalized decrease/loss of muscle tone; AND (ii) pallor or cyanosis; AND (iii) decreased level of awareness or loss of consciousness			MIN. HOURS		
STERILE ABSCESS/NODULE  No evidence of acute microbiological infecti	on	MIN.  HOURS	Sho	uld not be mistaken for	fainting, a post-convuls	sion state, or anap		
SEVERE PAIN AND/OR SEVERE SWELLING (tick one or both of the options below) (i) lasting 4 days or more		MIN. HOURS	DAYS		Mebrile	Yes 1	MIN. HOURS	
(ii) extending past nearest joint(s)					3) Afebrile seizures		No 🗌	
SCREAMING EPISODE/PERSISTENT CRY Inconsolable for 3 hours or more; OR quality	MIN. HOURS	DAYS and	Omit fainting, seizures occurring within 30 minutes of immunization and seizures occurring as part of encephalopathy or meningitis/en					
abnormal for child and not previously heard	by parents		Ac	CEPHALOPATHY ute onset of major neur	ological illness characte	erized by	IVIII V. TIOOTIO	
FEVER Highest recorded temperature (Report only 3 Temperature: °C (or	9.0°C (102.2° F) or above) °F)	MIN. HOURS	of o	two or more of: (i) seizonsciousness or menta re; (iii) focal neurologica	al status (behaviour an	d/or personality) I		
Site: rectal oral axilla  Temperature believed to be high but no Should be supported by the presence of	ot recorded	tympanic	Abi nes EN	ENINGITIS AND/OR EN normal CSF findings AND is or positive meningeal s CEPHALOPATHY above) sults of CSF examination	O an acute onset of: (i) fi signs; OR (ii) signs and	symptoms of ence	phalopathy (see	
ADENOPATHY (tick one or both of the option	ADENOPATHY (tick one or both of the options below)			AESTHESIA/PARAEST	THESIA		MIN. HOURS	
(i) enlarged lymph node(s) (ii) drainage of lymph node(s) Site(s)			Ge	sting over 24 hours neralized Localize	ed (indicate site)		MIN. [HOURS]	
PAROTITIS		MIN. [HOURS]	Pro	ogressive subacute wea bically symmetrical) with	kness of more than on		WIIV. HOORS	
Swelling with pain and/or tenderness of parotid gland(s)  ANAPHYLAXIS OR SEVERE SHOCK		MIN.  HOURS	* PA	RALYSIS (Do not code	if Guillain-Barré Syndrome is coded) al or cranial paralysis		MIN. HOURS	
Explosive, occurring within minutes after immu rapidly towards cardiovascular collapse AND re		erapy	De	scribe	- 1			
OTHER ALLERGIC REACTIONS (tick one or (i) wheezing or shortness of breath due to be		MIN. HOURS		ROMBOCYTOPENIA re lab results under Sup	oplementary Informati	on	MIN. HOURS	
(ii) swelling of mouth or throat (iii) skin manifestations (e.g., hives, eczema, pruritus) (iv) facial or generalized edema			Inc	t does not fit any of the	NUSUAL EVENTS  In believed to be related to immunization, ne categories listed above and for clearly established		MIN. HOURS	
RASHES (other than hives) Lasting 4 days or more AND/OR requiring h		MIN. HOURS	DAYS Re	port events of clinical in ents that are (i) fatal, (ii) result in residual disab	iterest which require m life-threatening, (iii) re-	edical attention, a quire hospitalization	and particularly on, or	
Generalized Localized (indicate sit Specify characteristics of rash	e)		DE	SCRIPTION				
ARTHRALGIA/ARTHRITIS Joint pain/inflammation lasting at least 24 hd If condition is an acute exacerbation of a pr diagnosis, give details under Supplementar	e-existing	MIN. HOURS	DAYS					
PORTER'S NAME	TELEPHONE	NUMBER	ADDR	ESS (Institution/No., S	street, etc.)			
OFESSIONAL STATUS: MD RN	OTHER							
or EcoloristE clivil co.   mb			City		Province		Postal Code	

	room, clinic, family physicia	an etc.) NO	YES (If yes, include rel	evant details of treatment ur	and the same believed to the same same and the	
OSPITALIZED BECAUSE OF EVENT(S)	NO YES	LENGTH OF STA	AY (DAYS)	DATE ADMITTED	Year Month	Day
ONCOMITANT MEDICATIONS (exclude those RUG(S) GIVEN	se used to treat the advers	se event)	MEDICAL HISTORY		n on relevant medical histor detailed instructions on rev	
			11.1			
	SUPI	PLEMENTAR	Y INFORMATION			
			-			
STRUCTIONS FOR COMPLET	TING REPORT OF	F A VACCINE-A	SSOCIATED ADVE	RSE EVENT		
Please use dark ink when						
Report only events which is conditions. A causal relation						ty.
Events marked with an ast INFORMATION box.						RY
Record interval between va						nto
Provide relevant information diagnosed by physician (se where a vaccinee is hospit of original records may be	ee 3 above), resultalised because of	Its of diagnostic	or laboratory tests, h	ospital treatment,	and discharge dia	gnose
Provide details of medical	history that are re	elevant to the acconcurrent illne	lverse event(s) repor sses which may be a	ted. Examples incl associated with the	ude a history of a	lergie event(
iii vaccinee, previous auvei						
O BE COMPLETED BY MEDICAL	HEALTH OFFICER	RECOMMENDA	TIONS FOR FURTHE	R IMMUNIZATION		
	HEALTH OFFICER	RECOMMENDA	ATIONS FOR FURTHE	RIMMUNIZATION		