



Health Canada

Santé Canada

In confidence to: Vaccine Adverse Events Surveillance Public Health Branch - Manitoba Health 4-300 Carlton Street Winnipeg, Manitoba R3B 3M9 Fax: 948-2040

REPORT OF A VACCINE-ASSOCIATED ADVERSE EVENT Protected when completed

IDENTIFICATION OF PATIENT NAME ADDRESS (NO., STREET, CITY) DATE OF BIRTH DATE OF VACCINE ADMINISTRATION SEX YEAR MONTH DAY

VACCINES table with columns: VACCINE(S) GIVEN, NUMBER IN SERIES, SITE, ROUTE, DOSAGE, MANUFACTURER, LOT NUMBER

ADVERSE EVENT(S) Events marked with an asterisk (*) must be diagnosed by a physician. Report only events which cannot be attributed to co-existing conditions.

LOCAL REACTION AT INJECTION SITE: INFECTED ABSCESS, STERILE ABSCESS/NODULE, SEVERE PAIN AND/OR SEVERE SWELLING, SCREAMING EPISODE/PERSISTENT CRYING, FEVER, ADENOPATHY, PAROTITIS, ANAPHYLAXIS OR SEVERE SHOCK, OTHER ALLERGIC REACTIONS, RASHES, ARTHRALGIA/ARTHRITIS. SEVERE VOMITING AND/OR DIARRHEA, HYPOTONIC-HYPORESPONSIVE EPISODE, CONVULSION/SEIZURE, ENCEPHALOPATHY, MENINGITIS AND/OR ENCEPHALITIS, ANAESTHESIA/PARAESTHESIA, GUILLAIN-BARRÉ SYNDROME, PARALYSIS, THROMBOCYTOPENIA, OTHER SEVERE OR UNUSUAL EVENTS.

REPORTER'S NAME TELEPHONE NUMBER ADDRESS (Institution/No., Street, etc.) PROFESSIONAL STATUS: MD RN OTHER SIGNATURE DATE Year Month Day City Province Postal Code



