ADVERSE EVENT FOLLOWING IMMUNIZATION FORM

Patient's Information: **Date:**

Patient Name:					Patient's Address:
Date of Birth:		Age:	_ _ (Years) or _ _ (Months)		
Gender: M ☐ F ☐ Other ☐	Height:	_____(cm)	Weight:	_____(Kg)	Contact Number"

Adverse event Details:

☐ Severe Local reaction ☐ > 3 days ☐ beyond nearest joint
☐ Seizures ☐ febrile ☐ afebrile
☐ Abscess
☐ Sepsis
☐ Encephalopathy
☐ Toxic shock syndrome
☐ Thrombocytopenia
☐ Anaphylaxis
☐ Fever ≥ 38^{0}C (Specify) ..... ^{0}C
☐ Other (Specify).....

Vaccine Adverse Event Term (Sign/ Symptoms/ Diagnosis)	Start date and Start Time	Stop Date and Stop Time	Grade The Following codes should be used: 1 = Mild 2 = Moderate 3 = Severe 4 = Life-threatening 5 = Fatal	Causal Relationship 1 = Not related 2 = Unlikely to be related 3 = Possibly related 4 = Probably related 5 = Definitely related
	(DD/MM/YYYY): _ _ / _ _ / _ _ _ _ (HH : MM) ____ : ____	(DD/MM/YYYY): _ _ / _ _ / _ _ _ _ (HH : MM) ____ : ____		

Severity: Mild ☐, Moderate ☐, Severe ☐

Seriousness of the reaction: No ☐ If Yes ☐ (Please tick below anyone)
☐ Death (dd/mm/yyyy) ☐ Congenital Anomaly ☐ Life Threatening
☐ Disability ☐ Hospitalization – Initial/Prolonged ☐ Other Medically Important

Outcome:
☐ Recovered ☐ Recovering ☐ Not Recovered ☐ Fatal ☐ Recovered with sequelae ☐ Unknown

Suspected Vaccine Details:

Vaccine Details							Diluent		
Name of the Vaccine	Brand name incl. Name of the Manufacturer	Date of Vaccination	Time of Vaccination	Dose (1st/2nd/3rd/ 4th/5th/ Booster)	Batch/Lot Number	Expiry Date	Batch/Lot Number	Expiry Date	Time of reconstitution

Relevant Medical History: Any other vaccination received within 4 weeks of the suspected vaccination, illness at the time of vaccination, Allergies, Birth defects, Birth weight, Medical condition, History of adverse evets following immunization, Vaccination in the patient or siblings etc.

Treatment Details: (any tests or diagnostics performed, attach reports)

Action taken after event: ☐ Discontinued the next dose ☐ Continued the next dose ☐ Not Applicable

Concomitant Vaccines, Medical Product including self-medication and herbal remedies with therapy dates (Exclude those used to treat reaction)

S. No.	Name (Brand/Generic)	Dose	Route	Frequency (OD, BD, etc.)	Therapy Dates		Indication
					Date started	Date stopped	

Reporter's Details:

Name: _____
Address: _____
_____& PIN: _____
Email ID: _____Contact No. _____
Occupation: _____
Sign with date & time: _____