Checklist of information to complete the VAERS form
(VAERS will still accept a report even if you cannot provide all this information)

Information about the PATIENT who received the vaccine
  o Name, address, phone number and email address
  o Date of birth
  o Sex (male or female)
  o Date and time of vaccination
  o Date and time the adverse event (health problem) started
  o Age at vaccination
  o Whether the patient was pregnant at the time of vaccination and the due date (for females only, if applicable)
  o Prescriptions, over-the-counter medications, dietary supplements and herbal remedies being taken
  o Allergies to medications, food, or other products
  o Other illnesses at the time of vaccination (and up to one month prior)
  o Chronic or long-standing health conditions

Information about the person completing or submitting the VAERS form
  o Name, address, phone number and email address
  o Relation to the patient (for example: healthcare professional, parent, caregiver, etc.)

Information about the healthcare professional
  o Name and phone number for the best doctor or healthcare professional to contact to get more information about the patient and the adverse event

Information about the facility (or place) where the vaccine was given
  o Facility/clinic name, fax number, address and phone number
  o Facility type (for example: doctor’s office or hospital, pharmacy or drug store, workplace clinic, etc.)

Information about which vaccines were given and what happened to the patient
  o Vaccine type and brand name, manufacturer, and lot number
  o How the vaccine was given (route of administration, body site where given, and dose number if the vaccine was part of a series)
  o Description of the adverse event, including medical treatment and diagnosis
  o Results of medical tests and laboratory tests
  o Outcome of the adverse event (for example: doctor office visit, emergency room visit, hospitalization, etc.)
  o Whether the patient has recovered from the adverse event

Additional information
  o Any other vaccines received by the patient within a month prior to the current vaccine(s) (include vaccine type and brand name, manufacturer, lot number, and how the vaccine was given)
  o Adverse event(s) after previous vaccinations
  o Patient’s race and ethnicity