

Vaccine Incident Reporting Form

1. CLIENT INFORMATION

Name: _____ DOB: YYYY/MM/DD _____

Parents/Guardian: _____ Community: _____

Incident Date: _____

Vaccine(s) Involved (include lot numbers if possible):

Vaccine name/generic	Lot number

2. TYPE OF INCIDENT (circle from the choices below, or if not there, please select other and provide a description of the incident below)

Wrong vaccine

Incorrect label/directions

Expired

Exposed to cold chain break but not yet verified ok for use

Timing (given too early or too late -provide timing

Dose (wrong # in schedule; incomplete dose)

Administration (wrong route; incorrect dosage)

Other: (describe) _____

3. DESCRIBE WHAT HAPPENED: (include any issues, immediate actions taken, the highest impact of the incident and the client outcome at the time of reporting)

4. **CONTRIBUTING FACTORS:** (Eg. condition of client prior to incident, busy clinic)

5. **SUGGESTIONS TO PREVENT FUTURE INCIDENTS:**

DATE _____ Name of Reporting Nurse (please print) _____ Signature of Reporting Nurse _____

NOTIFICATION (complete according to policy)

1. Date Client/Guardian notified: _____
2. Date Supervisor notified _____
3. Date Immunization Coordinator/MHO notified: _____

Condition of Client

- No change in client's condition; no intervention required
- Minor: temporary systemic or localized response; no ongoing complications
- Major: Required immediate medical intervention

Keep a copy of this form in the client's chart.