

**Apéndice L:  
Hoja de VAERS**



**VACCINE ADVERSE EVENT REPORTING SYSTEM**

24 Hour Toll-Free Information 1-800-822-7967

P.O. Box 1100, Rockville, MD 20849-1100

**PATIENT IDENTITY KEPT CONFIDENTIAL**

*For CDC/FDA Use Only*

VAERS Number \_\_\_\_\_

Date Received \_\_\_\_\_

Patient Name: \_\_\_\_\_  
 Last First M.I.  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 City State Zip  
 Telephone no. (\_\_\_\_) \_\_\_\_\_

Vaccine administered by (Name): \_\_\_\_\_  
 Responsible Physician \_\_\_\_\_  
 Facility Name/Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 City State Zip  
 Telephone no. (\_\_\_\_) \_\_\_\_\_

Form completed by (Name): \_\_\_\_\_  
 Relation  Vaccine Provider  Patient/Parent  
 to Patient  Manufacturer  Other  
 Address (if different from patient or provider) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 City State Zip  
 Telephone no. (\_\_\_\_) \_\_\_\_\_

1. State \_\_\_\_\_ 2. County where administered \_\_\_\_\_ 3. Date of birth    /   /    4. Patient age \_\_\_\_\_  
 mm dd yy

7. Describe adverse events(s) (symptoms, signs, time course) and treatment, if any  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Check all appropriate:  
 Patient died (date    /   /   )  
 Life threatening illness    /   /     
 Required emergency room/doctor visit  
 Required hospitalization (\_\_\_\_ days)  
 Resulted in prolongation of hospitalization  
 Resulted in permanent disability  
 None of the above

9. Patient recovered  YES  NO  UNKNOWN

10. Date of vaccination    /   /    AM/PM \_\_\_\_\_  
 mm dd yy  
 Time \_\_\_\_\_ PM  
 11. Adverse event onset    /   /    AM/PM \_\_\_\_\_  
 mm dd yy  
 Time \_\_\_\_\_ PM

12. Relevant diagnostic tests/laboratory data  
 \_\_\_\_\_  
 \_\_\_\_\_

13. Enter all vaccines given on date listed in no. 10

Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous Doses
a. _____	_____	_____	_____	_____
b. _____	_____	_____	_____	_____
c. _____	_____	_____	_____	_____
d. _____	_____	_____	_____	_____

14. Any other vaccinations within 4 weeks prior to the date listed in no. 10

Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous doses	Date given
a. _____	_____	_____	_____	_____	_____
b. _____	_____	_____	_____	_____	_____

15. Vaccinated at:  
 Private doctor's office/hospital  Military clinic/hospital  
 Public health clinic/hospital  Other/unknown

16. Vaccine purchased with:  
 Private funds  Military funds  
 Public funds  Other/unknown

17. Other medications  
 \_\_\_\_\_  
 \_\_\_\_\_

18. Illness at time of vaccination (specify)  
 \_\_\_\_\_  
 \_\_\_\_\_

19. Pre-existing physician-diagnosed allergies, birth defects, medical conditions (specify)  
 \_\_\_\_\_  
 \_\_\_\_\_

20. Have you reported this adverse event previously?  
 No  To health department  
 To doctor  To manufacturer

*Only for children 5 and under*  
 22. Birth weight \_\_\_\_\_ lb. \_\_\_\_\_ oz.  
 23. No. of brothers and sisters \_\_\_\_\_

21. Adverse event following prior vaccination (check all applicable, specify)

Adverse Event	Onset Age	Type Vaccine	Dose no. in series
<input type="checkbox"/> In patient _____	_____	_____	_____
<input type="checkbox"/> In brother or sister _____	_____	_____	_____

*Only for reports submitted by manufacturer/immunization project*  
 24. Mfr./imm. proj. report no. \_\_\_\_\_  
 25. Date received by mfr./imm.proj. \_\_\_\_\_  
 26. 15 day report?  Yes  No  
 27. Report type  Initial  Follow-Up

Health care providers and manufacturers are required by law (42 USC 300aa-25) to report reactions to vaccines listed in the Table of Reportable Events Following Immunization. Reports for reactions to other vaccines are voluntary except when required as a condition of immunization grant awards.

"Fold in thirds, tape & mail — DO NOT STAPLE FORM"



NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE  
UNITED STATES  
OR APO/FPO

**BUSINESS REPLY MAIL**

FIRST-CLASS MAIL PERMIT NO. 1895 ROCKVILLE, MD

POSTAGE WILL BE PAID BY ADDRESSEE



**VAERS**

P.O. Box 1100

Rockville MD 20849-1100



**DIRECTIONS FOR COMPLETING FORM**

(Additional pages may be attached if more space is needed.)

**GENERAL**

- Use a separate form for each patient. Complete the form to the best of your abilities. Items 3, 4, 7, 8, 10, 11, and 13 are considered essential and should be completed whenever possible. Parents/Guardians may need to consult the facility where the vaccine was administered for some of the information (such as manufacturer, lot number or laboratory data.)
- Refer to the Reportable Events Table (RET) for events mandated for reporting by law. Reporting for other serious events felt to be related but not on the RET is encouraged.
- Health care providers other than the vaccine administrator (VA) treating a patient for a suspected adverse event should notify the VA and provide the information about the adverse event to allow the VA to complete the form to meet the VA's legal responsibility.
- These data will be used to increase understanding of adverse events following vaccination and will become part of CDC Privacy Act System 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems". Information identifying the person who received the vaccine or that person's legal representative will not be made available to the public, but may be available to the vaccinee or legal representative.
- Postage will be paid by addressee. Forms may be photocopied (must be front & back on same sheet).

**SPECIFIC INSTRUCTIONS**

Form Completed By: To be used by parents/guardians, vaccine manufacturers/distributors, vaccine administrators, and/or the person completing the form on behalf of the patient or the health professional who administered the vaccine.

- Item 7: Describe the suspected adverse event. Such things as temperature, local and general signs and symptoms, time course, duration of symptoms, diagnosis, treatment and recovery should be noted.
- Item 9: Check "YES" if the patient's health condition is the same as it was prior to the vaccine, "NO" if the patient has not returned to the pre-vaccination state of health, or "UNKNOWN" if the patient's condition is not known.
- Item 10: Give dates and times as specifically as you can remember. If you do not know the exact time, please  
and 11: indicate "AM" or "PM" when possible if this information is known. If more than one adverse event, give the onset date and time for the most serious event.
- Item 12: Include "negative" or "normal" results of any relevant tests performed as well as abnormal findings.
- Item 13: List ONLY those vaccines given on the day listed in Item 10.
- Item 14: List any other vaccines that the patient received within 4 weeks prior to the date listed in Item 10.
- Item 16: This section refers to how the person who gave the vaccine purchased it, not to the patient's insurance.
- Item 17: List any prescription or non-prescription medications the patient was taking when the vaccine(s) was given.
- Item 18: List any short term illnesses the patient had on the date the vaccine(s) was given (i.e., cold, flu, ear infection).
- Item 19: List any pre-existing physician-diagnosed allergies, birth defects, medical conditions (including developmental and/or neurologic disorders) for the patient.
- Item 21: List any suspected adverse events the patient, or the patient's brothers or sisters, may have had to previous vaccinations. If more than one brother or sister, or if the patient has reacted to more than one prior vaccine, use additional pages to explain completely. For the onset age of a patient, provide the age in months if less than two years old.
- Item 26: This space is for manufacturers' use only.

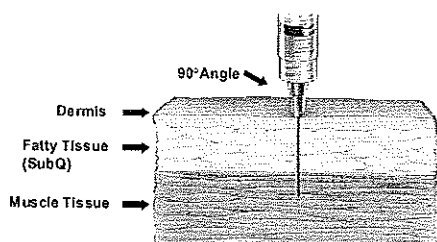
**Apéndice M:  
Técnicas de Aplicación  
para Vacunación**

# Técnica de Aplicación para Vacunación

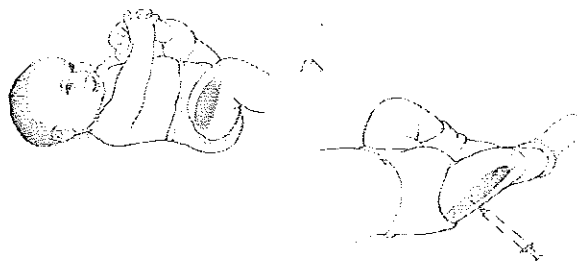
La elección del lugar depende de:

- Edad de la persona
- Desarrollo muscular
- Utilice el músculo deltoides en niños mayores y adultos (en los niños sólo si la masa muscular es adecuada)
- Utilice el músculo antero lateral en infantes y niños pequeños  
Utilice la localización anatómicas para identificar el sitio

## Intramuscular (IM) Tissue

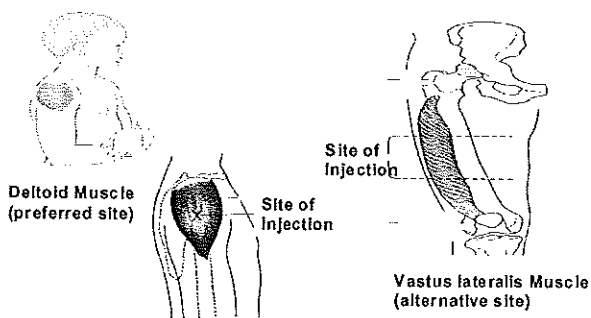


## IM Site - Infant



Anterolateral Thigh (vastus lateralis muscle)

## IM Sites Child/Adolescent/Adult



## Geringuillas Intramusculares

Calibre: diámetro de las agujas, en numero "G" 22 a 25

Longitud: en pulgadas

- Recién nacido 5 / 8 pulgadas
- Infantil de 1 pulgada
- Niños mayores 5 / 8 \* a 1 ¼ pulgadas
- Los adolescentes / adultos 1 a 1 ½ pulgadas

## Dosis y lugar de administración Intranasal

La mitad de la dosis (0,1 ml) se administra en cada fosa nasal, mientras el paciente se encuentre sentado. Inserte la punta de la bomba justo dentro de la nariz y presione el émbolo hasta que el separador (clip) del divisor de la dosis le impida ir más allá. Elimine el separador (clip) de la dosis del rociador para administrar la segunda mitad de la dosis (0,1 ml) en el otro orificio nasal. Si el paciente estornuda, la dosis no es necesaria ser readministrada nuevamente.

