Adverse Event Clinical Form

Date: | | | | | | | | |
DD/MM/YYYY

Vaccine Name:

Batch Number:

Student's Name:

Date of Birth:
DD/MM/YYYY

Address:

Phone:

School/Clinic:

GP:

GP Address:

Name of staff member______________________________ Dr/Nurse

Adverse event

Onset of symptoms after vaccination	Minutes	Hours	Days
Nature of symptoms			

Anaphylactic reaction

Skin/mucosal reaction	Tick if present	Respiratory reaction	Tick if present
Generalised urticaria or erythema		Acute breathing trouble	
Generalised itching with skin rash		Bilateral bronchospasm	
Generalised itching without skin rash		Stridor	
Angio-odema		Swelling of upper airways: Lips/ tongue/pharynx/uvula/larynx	
Red and itchy eyes		Tachypnoea	
Localised urticaria at injection site		Cyanosis	
Cardiovascular reaction		Expiratory ronchus	
Hypotension		Enforced use of breathing aid muscles	
Circulatory shock		Dry cough	
Tachycardia		Hoarseness	
Loss of consciousness		Sneezing	
Consciousness disorder		Rhinorrhoea	
Reduced central pulse volume			
Capillary refill time >3 sec			
Gastrointestinal		***Gastrointestinal***	
Nausea		Diarrhoea	
Vomiting		Abdominal pain	

Time	Pulse Rate	Resp. Rate	Blood Pressure	Observations	Signature

Outcome and follow-up including treatment

Reported to HPRA: **Yes** ☐ **No** ☐

Date ☐☐☐☐☐☐☐☐ **(DD/MM/YYYY)**

Signature ______________________________