

INCIDENT REPORT



Date: _____ Type of Event: Flu Screening Other: _____
Event ID: _____ Event Location Address: _____
Participant's Name: _____

Primary Reason(s) for Completing Report:

Allergic/Adverse Reaction Epinephrine Administration Client Problem Vaccine Refusal
Equipment/Supply Problem/Reconciliation HIPAA Other: _____

Please contact your account manager as soon as possible after an incident occurs. If you need to leave a message, please include your name, the event location (company, city, state) and a brief description of the event so that we know to look for the Incident Report in your return shipment or online event summary. Note that any suspected adverse events following immunizations are to be reported by the healthcare professional to the Vaccine Adverse Event Reporting System (VAERS) under the U.S. Department of Health and Human Services (DHHS) at the following website, <https://vaers.hhs.gov/reportevent.html>.

Flu Shot Event

If you witness an adverse reaction, whether or not you had to administer epinephrine, record the following information:

Administering Nurse: _____ Injection Site: _____
Immunizing Agent: _____ Manufacturer: _____
Lot Number: _____
Current illness(es) and/or medications: _____
Timing of vaccination and onset of adverse event: _____
Demographic information (age, gender, etc.): _____
Notes:

Screening Event

Primary Contractor

Printed Name: _____ Signature: _____

If you need additional space, you may write on the back of, or attach paper to, this Incident Report.