

Adverse Reaction to Vaccination

Please complete this report if you have observed any adverse reactions to vaccination within 30 days of the vaccination being given

Name of person who reacted: _____

Street Address: _____

City/State/Postcode: _____

Telephone: _____ Fax: _____ Mobile: _____

Email: _____ URL: _____

If the person who reacted was under the age of 18 at the time of the reaction please fill in the following section:

Child's Parent or Gaurdian: _____

Date of Birth: _____ Date of first reaction: _____

(note - names and addresses are confidential unless permission is given to share with media, government and solicitors who may be taking compensatory cases on behalf of vaccine injured individuals in the future)

Vaccine History:

Please list the dates that the following vaccines were administered-

Diphtheria/Tetanus/Pertussis (DPT) 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Diphtheria/Tetanus/acellular Pertussis (D Tap) 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Oral Polio (OPV) 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Injected Polio (IPV) 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Hepatitis B (Hep B) 1st _____ 2nd _____ 3rd _____

Measles/Mumps/Rubella (MMR) 1st _____ 2nd _____ 3rd _____

Haemophilus influenza (Hib) 1st _____ 2nd _____

Chicken Pox (varicella) 1st _____ 2nd _____ 3rd _____

Vitamin K (please specifyif oral or injected) dates of all given: _____

Any other vaccines _____

Note: It is important that you provide us with information that is as accurate as possible. We realise that it may have been some time since these reactions took place and therefore, if you do not have the exact dates that vaccines were administered, please provide us with the month and year or, if necessary, just the year.

Vaccine Reactions

Where you or your child seen by a doctor at the time the vaccine was administered? _____

Were you warned about the possibility of vaccine side-effects or failures? _____

Did you or your child have any symptoms of illness at the time? (please describe symptoms - if you need more space, please attach a separate page) _____

Were you or your child on any medications at the time? ____ Which ones? _____

What was the date of the first reaction? _____ Batch no.(s) _____

Was vaccination named as a cause of illness by doctor? _____

Name and address of administering doctor/clinic _____

What treatment was prescribed for the reaction? _____

How much time was there between the vaccination and the symptoms? _____

Please describe the reaction (attach another page if necessary): _____

Did you or your child develop any of the following within 30 days of vaccination? (please tick)

Swelling at site

Fever

Skin Rash

Vomiting/Nausea

Screaming-how long__

Persistent Cry-how long

Convulsion/Seizure

Ear Pain

Breathing difficulties

Change in bowel patterns

Meningitis

Encephalitis

Other (please describe) _____

Was the birth normal? _____ Caesarian? _____

Other intervention _____

Was the child breast fed? _____ How long? _____

Did your child have any chronic health conditions (allergies etc.) before vaccination? _____

Please describe conditions: _____

Did your child have any chronic health conditions after vaccination? _____

Please describe: _____

Has the person who's reaction is being reported contracted any diseases they were being vaccinated against? Which ones: _____ Doctor diagnosed? _____

How long after vaccination? _____

What is the present condition of the person for whom this report is being entered? _____

The Australian Vaccination Network would like to thank you for taking the time to fill out this reaction report form. If you would like to learn about any possible legal actions planned on behalf of vaccine-victims, please tick here . If you feel able to share your story with the media, please tick here . If you would like us to report this reaction to the government, please tick here .

Please fill this form out and return it to:

AVN
PO Box 177
Bangalow NSW 2479