STATE OF KUWAIT
MINISTRY OF HEALTH
Drug & Food Control
Pharmaceutical & Herbal Medicines
Registration & Control Admn.

دولة الكويت
وزارة الصحة
الرقابة الدوائية والغذائية
إدارة تسجيل ومراقبة
الأدوية الطبية والنباتية

Vaccines Adverse Event Reporting Form (VAER)

1. Patient Details:

Name:	Civil ID:	Nationality:
Date of birth:	Gender: ☐ Male ☐ Female	Age at vaccination: ….Years ……Months…..Days
Address:	Phone number :	E-mail :

Pregnant at time of vaccination?: ☐ Yes ☐ No ☐Unknown
(If yes, describe the event, any pregnancy complications, and estimated due date if known)

2. Health Facility (place or vaccination center) :

Name:	Type (Government , Private)	Address:	Phone Number :

3. Vaccine / Vaccination Program :

Name of vaccine	Type of vaccination program (Mandatory ,Voluntary)	Date and time of vaccination	Route of administration	Dose (1st, 2nd, etc.)	Batch /Lot number	Expiry date

4. Description of adverse reaction:

Describe the adverse event(s), treatment, and outcome(s), if any: (symptoms, signs, time course, etc.)

Past medical history (including history of similar reaction or other allergies), concomitant medication and other relevant information (e.g. other cases).

Medical tests and laboratory results related to the adverse event(s): (include dates)

Has the patient recovered from the adverse event(s)? ☐ Yes ☐ No ☐ Unknown

Result or outcome of adverse event(s):

- ☐ **Doctor or other healthcare professional office/clinic visit**
- ☐ **Emergency room/department or urgent care**
- ☐ **Hospitalization:**

Number of days (if known)
Hospital name:

- ☐ **Prolongation of existing hospitalization (vaccine received during existing hospitalization)**
- ☐ **Life threatening illness (immediate risk of death from the event)**
- ☐ **Disability or permanent damage**
- ☐ **Patient died**

Date of death: (……./……. /…..…)

- ☐ **Congenital anomaly or birth defect**
- ☐ **Other**

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Date reaction started:	**Date reaction stopped:**

5. Reporter data: **(All data will be kept confidential)**

Name:	Profession(Specialty):	Date:
Email:	Phone:	Signature:

Please send this form by fax to: 24837245
It's easy to report online to adr_reporting@moh.gov.kw
Note: identities of reporter, patient and institution will remain confidential