COVID-19 VACCINATION CLINIC INCIDENT REPORT FORM

Note: for blood borne pathogen incident (needle stick, etc.), use the incident form in the current COVID-19 Standing Order document

Today's Date: _____

Date of Incident: _____ Time of Incident: _____

STAFF REPORTING:

Staff Name: _____ Phone Number: _____

E-mail Address: _____

Clinic Name/Location: _____

TYPE OF INCIDENT:

_____ Vaccine administration error ____ Vaccine reaction ____ Seizure
_____ Other (brief description_____)
Reported through VAERS? If so, report number: _____

Name of Vaccine:_____ Site: _____ Lot Number: _____
Patient Name: _____DOB: _____
Patient Phone Number: _____
E-mail Address: _____

DESCRIPTION OF EXPOSURE/INCIDENT:

Actions Taken:

Outcome:

Health Care Provider Contacted: Yes ____ No_____ If so, date/time:

Name and phone number of provider: _____

Call On-Call Provider to report.
Upload this form to On-Site Medical Services Secure Dropbox