Report of Adverse Event Following Immunization (AEFI)

Public Health Ontario | Santé publique Ontario

When completed, please send the form to your local Public Health Unit by a secure means. For more information about AEFI reporting in Ontario visit the Public Health Ontario website.
The form should be used to capture AEFIs for all vaccines.

Case ID
(for local use only):

1 - CLIENT AND REPORTING SOURCE INFORMATION

Client last name:

Ontario Health Card #:

Given name(s):

Date of Birth (yyyy-mm-dd):

Sex: ☐ Male ☐ Other ☐ Female ☐ Unknown

Parent/guardian/caregiver full name, as applicable:

Telephone #:

Address:

City:

Postal Code:

Reported to public health by:

Relationship with case:

Form completed by:

Date of report (yyyy-mm-dd):

Contact information of reporter (if different from above):

2 - IMMUNIZATION INFORMATION

Date (yyyy-mm-dd)	Time (24hr - HH:MM)	Manufacturer / Trade Name	Lot #	Lot exp. Date (yyyy-mm-dd)	Dose #	Site	Route

Immunization error: ☐ No ☐ Unknown ☐ Yes* Describe in Section 5

Where vaccine administered (e.g., pharmacy):

Vaccine administered by: Name:

Designation:

3 - ADVERSE EVENT INFORMATION

A. Report only events which cannot be attributed to co-existing conditions.
B. Reactions marked with an asterisk (*) must be diagnosed by a physician or a nurse practitioner.
C. Record the **time to onset of the event** (time between vaccine administration and onset of each event) and the **duration** of each event in **minutes** or **hours** or **days** (if recovered). If the interval / duration is less than one hour record in minutes, if less than 24 hours record in hours, if greater than or equal to 24 hours record in days.

Local Reaction at the Injection Site	Specify minutes or hours or days: Time to onset of event	Duration of event
☐ Pain / redness / swelling extending past nearest joint		
☐ Pain / redness / swelling lasting **4 days or more**		
☐ Infected abscess		
☐ Sterile abscess		
☐ Nodule		
☐ Cellulitis		
☐ Adenopathy / lymphadenopathy*		

Systemic Reactions	Time to onset of event	Duration of event
☐ Fever 38.0ºC or greater (Only reportable in conjunction with another event)		
☐ Rash		
☐ Hypotonic-hyporesponsive episode (HHE)*		
☐ Persistent crying / screaming (infants and young children only)		
☐ Severe vomiting / diarrhea (3 episodes/24 hours)		
☐ Parotitis*		

Allergic Reactions	Time to onset of event	Duration of event
☐ Event managed as anaphylaxis		
☐ Oculorespiratory syndrome (ORS)		
☐ Allergic reaction - skin / mucosal (e.g., hives)		

Neurologic Reactions	Specify minutes or hours or days: Time to onset of event	Duration of event
☐ Convulsions / seizure		
☐ Encephalopathy / encephalitis*		
☐ Bell's Palsy*		
☐ Anaesthesia / paraesthesia*		
☐ Meningitis*		
☐ Paralysis*		
☐ Guillain-Barré Syndrome (GBS)*		
☐ Myelitis / Transverse Myelitis*		
☐ Acute disseminated encephalomyelitis*		

Other events of interest	Time to onset of event	Duration of event
☐ Thrombocytopenia*		
☐ Arthritis / Arthralgia		
☐ Intussusception*		
☐ Syncope (fainting) with injury		
☐ Kawasaki Disease*		
☐ Myocarditis / Pericarditis*		
☐ Coagulation disorder (including thrombotic events)*		
☐ Thrombosis with thrombocytopenia syndrome (TTS)*		
☐ Single organ cutaneous vasculitis*		
☐ Multisystem Inflammatory Syndrome in children / adults*		
☐ Erythema multiforme*		
☐ Other severe or unusual events		

Client last name: | Given name(s): | Date of Birth (yyyy-mm-dd):

Describe all events in Section 5

4 - MEDICAL HISTORY

Please provide a detailed description of the client's medical history (e.g. immunocompromised, immunosuppressed, chronic illness / underlying medical conditions), concomitant medications, history of allergies.

Previous history of AEFI: ☐ No ☐ Unknown ☐ Yes* Describe in Section 5

Pregnant at the time of immunization: ☐ Yes ☐ No ☐ Unknown If yes, gestation (weeks):

5 - COMMENTS FURTHER DESCRIBING THE ADVERSE EVENT(S)

Please provide a detailed description of the event including all signs and symptoms, investigation, treatment, hospitalization details, and description of previous history of AEFI if indicated in Section 4 or immunization error if indicated in Section 2.

6 - HEALTH CARE UTILIZATION & OUTCOME

Please provide information about health care utilization related to the event. Outcome to be updated by the Public Health unit when the investigation is complete.

Medical consultation (non-urgent) ☐ Yes ☐ No Date (yyyy-mm-dd)

Seen in emergency department ☐ Yes ☐ No Date (yyyy-mm-dd)

Admitted to hospital because of event ☐ Yes ☐ No Admission Date (yyyy-mm-dd)

Discharge Date (yyyy-mm-dd)

Health professional attending the event:

Name:

Address:

Name of facility where the event was attended to (e.g., hospital name):

OUTCOME ☐ Recovered ☐ Not yet recovered (describe below) ☐ Persistent or significant disability / incapacity (describe below) ☐ Unknown ☐ Death (describe below)

Describe: Date of outcome: (yyyy-mm-dd)

Client last name: Given name(s): Date of Birth (yyyy-mm-dd):

The personal health information provided on this form is collected under the authority of the *Health Protection and Promotion Act* and O. Reg 569. The personal health information is used to signal adverse events that may require more in-depth investigation and to ensure the continued safety of vaccines on the Canadian market by monitoring adverse events following immunization with vaccines. The information collected may be shared with the Public Health Agency of Canada. If you have questions about the collection of this personal health information please contact your local public health unit.

FOR PUBLIC HEALTH UNIT USE ONLY - DO NOT TRANSMIT

7 - MEDICAL OFFICER OF HEALTH / ASSOCIATE MEDICAL OFFICER OF HEALTH (A / MOH) RECOMMENDATIONS

For Public Health Unit use only. To be completed by the MOH or designate.

Check all that apply:

- ☐ No recommendation
- ☐ No change to immunization schedule
- ☐ Determine protective antibody levels (Specify)
- ☐ Active follow-up for AEFI recurrence after next vaccine
- ☐ Controlled setting for next immunization
- ☐ Expert referral (Specify)
- ☐ No further immunization (Contraindication or series complete - Specify)
- ☐ Other (Specify)

A / MOH recommendation comments:

Medical Officer of Health (MOH) or Designate

Name: _____ Date (yyyy-mm-dd): _____

Signature: _____

Updated July 2025

Ontario