Please note that, aside from filing this report, you should still talk to your doctor or pharmacist if you are worried about suspected adverse reactions or an incident.

Mandatory fields are indicated with a red asterisk \*. Your report can only be processed if these have been completed.

**Person concerned**

Age in years \* Age

Patient’s gender \* [ ]  m [ ]  f [ ]  other Weight in kg Weight Height in cm Height

**Vaccine**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of the COVID-19 vaccine used \***¹** | Batch number | Date of first vaccination\* | Date of second vaccination (if any) | Date of third vaccination (if any) | Suspected as cause of side effect |
| Vaccine | Batch | X | X | Date | [ ]  yes [ ]  no |
| Vaccine | Batch | X | Date | X | [ ]  yes [ ]  no |
| Vaccine | Batch | Date | X | X | [ ]  yes [ ]  no |

**¹**(may be taken from vaccine certificate, for example)

**Side effect**

|  |  |
| --- | --- |
| What side effect has occurred? Please describe the side effect in as much detail as possible (symptoms, diagnosis/findings, treatment, course) \* | Side effect |

On what date did the side effect first occur? Date

On what date was the side effect last present? Date

What is your current state of health (please check only one box)?

[ ]  back to normal

[ ]  general improvement

[ ]  not yet back to normal

[ ]  lasting impairment

[ ]  person concerned has died

[ ]  unknown

The impairment to health resulting from the side effect(s) (please check as many boxes as applicable)

[ ]  was slight

[ ]  was serious

[ ]  was life-threatening

[ ]  resulted in (extended) hospitalisation

[ ]  resulted in death

**Further information**

Were you pregnant at the time of the vaccination against COVID-19? [ ]  yes [ ]  no

Were you breastfeeding at the time of the vaccination against COVID-19? [ ]  yes [ ]  no

Do you drink alcohol? [ ]  no [ ]  seldom [ ]  often

Do you smoke? [ ]  no [ ]  used to [ ]  yes

|  |  |
| --- | --- |
| Do you have any allergies (e.g. foods, medicines, pollen)? | Allergies |
| Do you have any existing health disorders (e.g. diabetes, high blood pressure, impaired kidney function, liver disease, cancer)? | Pre-existing diseases |

**Are you taking any other medicines? (co-medication)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of the medicine (as shown on the pack) | Method of administration (tablets, drops, injection, ointment, suppositories, plaster) | Dosage (e.g. per day) | Start of treatment | End of treatment | Reason for treatment (e.g. high blood pressure) | Suspected as cause of side effect |
| Medication | Dosage form | Dosage | Date | Date | Reason | [ ]  yes [ ]  no |
| Medication | Dosage form | Dosage | Date | Date | Reason | [ ]  yes [ ]  no |
| Medication | Dosage form | Dosage | Date | Date | Reason | [ ]  yes [ ]  no |

**Contact details of reporting person**

|  |  |
| --- | --- |
| E-mail  | E-mail |
| Tel.  | Tel. |

The side effect has occurred in:

[ ]  me [ ]  my child [ ]  other family member: Family members

**Submit report**

|  |  |
| --- | --- |
| Swissmedic will process the personal data transmitted in this report form in accordance with Art. 61 ff. TPA.All persons tasked with processing the data are obliged to maintain professional secrecy.Particularly sensitive personal data will be anonymised as far as possible. | Date of submission \* Date |

Please use the following details for transmission to Swissmedic

E-mail address: vigilance@swissmedic.ch

Subject COVID-19 vaccine report