

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07028

Product Code: 2100.02 1599.20 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Bronchicine CAe	189		<input checked="" type="checkbox"/> Combination
2 Vanguard 5/CV	189		<input checked="" type="checkbox"/> Viral
3 Defensor 3	189		<input checked="" type="checkbox"/> Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1		R side		
2		L side		
3		R side		
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/09/2006
Concurrent Drugs or Procedures:	CA-fecal exam

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
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Explain the event and any treatment in a concise paragraph:  
 we have 3 toy poodles who were all vaccinated on 1/9/06 with the drugs above. They now have patches of bare skin where hair will not grow where the shots were given. The patches are about 2" in diameter and the same on all 3 dogs. Our veterinarian advised us that she had a "bad batch" from Pfizer and they knew about it. She did not contact

us - we had to contact her about our concerns. She advised that the hair may never grow back. She did not know. She did advise us that Pfizer knew and offered no other explanation. We have gone on the Pfizer website in order to find out something but have been unable. Our veterinarian has also not been of any help. We would like to know what is going on with the shots. DH LP/P/CORONA administered on left side. Rabies vaccine (3 yr); bronch. cae inj. given on left side.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 mos
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:3
(Other Species):		Number affected:3
Breed:	Toy Poodles	Number vaccinated:3
Sex:	<input checked="" type="checkbox"/> Male	Number dead:0
Neutered:	<input checked="" type="checkbox"/> Not Listed	
Age (i.e., 2 yrs or 2 mos):	2 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	SC
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to  Yes

the manufacturer(s):	
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	XXX-XXX-XXXX)
*Today's Date:	06/27/2006(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/11/2006  
 Verified:yes  
 Reviewed:yes  
 Date Entered: 11/21/2006  
 CVB Reporter:  
 Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

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 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07084

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	S603744E	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ	R hind	22	11/01/2006
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/17/2006
Concurrent Drugs or Procedures:	none

## Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: A <0.5cm lump was notice by the owner on 12/12/2006. Told owner to observe and recheck in 2 weeks if still there then aspirate and concider sx removal. If grows then biopsy.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	6 wks
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	Still observation.

**Animal Information**

Case Identification:	Bailey	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1 yr, 10 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): In door cat post vaccination swelling noticed by owner 3 weeks post.			

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	NM
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6) (XX)	Phone	(b)(6) (XX-XXX-XXXX)
FAX			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) (X-XXX-XXXX)
*Today's Date:	12/13/2006 (MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 12/13/2006

Verified:yes

Reviewed:yes

Date Entered: 12/26/2006

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

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 510 South 17th Street, Suite 104  
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 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07098

Product Code: 46E5.21 1905.24 13D1.25

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 CvK/LCI-GP	112	094177A	<input checked="" type="checkbox"/> Combination
2 Defensor 3	189	A600199C	<input checked="" type="checkbox"/> Viral
3 Duramune Max 5	112	116817A	<input checked="" type="checkbox"/> Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Between shoulder blade	22	11/07/2006
2 1 ml	SQ	Between shoulder blade	22	11/07/2006
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/07/2006
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: within 10 minutes of vaccination animal had pale mucous membranes, tachycardia, dilated pupils, recumbant, seized within 45 minutes, within 1 to 2 hours after treatment back to normal. Prednisone, IV fluids, antihistamine, diazepam	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	within 10 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

#### Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Springer Spaniel	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos): 1.5 yrs	

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):  
Same 5 way administered 09/13/2005, 10/15/2005, and 11/03/2005; RV given 10/05/2005 all no reactions.

#### Personal Information

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	MI
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) XXX-XXX-XXXX
FAX	(b)(6)		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)
*Today's Date:	11/16/2006(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/16/2006

Verified:yes

Reviewed:yes

Date Entered: 02/14/2007

CVB Reporter: Huls

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

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 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
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Record Number: AIV07126

Product Code: 13D1.T0 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Adult	112	1798108A	<input checked="" type="checkbox"/> Combination
2 Rabdomun 1	189	A601264A	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L shoulder	22	02/05/2007
2 1 ml	SQ	R rear	22	02/05/2007
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/05/2007
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Dog vomited within an hour of receiving vaccines. Was trembling but otherwise fine. Administered diphenhydramine.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	<60 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

**Animal Information**

Case Identification: Buster	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1	
(Other Species):	Number affected: 1	
Breed: Pug	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):  
 Had received Pfizer Defensor 3 rabies vaccine in past (2/4/03 and 1/29/04) without incident. Received Ft Dodge Duramune Max 5 2/4/03 without incident.

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name:	
Address		Address:	
City		City:	
State		State:	
Zip		Zip:	
*Phone		Phone: (XXX-XXX-XXXX)	
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	
*Today's Date:	02/07/2007 (MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Veterinarian
Other:

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/07/2007

Verified:yes

Reviewed:yes

Date Entered: 02/14/2007

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

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 Phone: (515) 232-5785  
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Record Number: AIV07129

Product Code: 1905.24 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabdomun 1	189	A130617B	<input checked="" type="checkbox"/> Viral
2 Rabdomun 1	189	A352009B	<input checked="" type="checkbox"/> Viral
3			
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip	unknown	11/01/2007
2 1 ml	SQ	R hip	unknown	11/01/2007
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/12/2004
Concurrent Drugs or Procedures:	Rabies vax - Rrear; FVRCP - Lrear

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Neoplasia/Cancer
Explain the event and any treatment in a concise paragraph: patient noticed swelling on right hip 01/04/07. FNA - 01/06/07 revealed probable malignant fibrous histiocytoma. growth removal - 01/10/07 - fibrosarcoma, high grade malignancy.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?) (Include Units:mins, hrs, days, wks, mos, yrs)	unknown which vacine may have led to event
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	removed mass; 3-6 mos expected survival

#### Animal Information

Case Identification:	6714 - Buddy	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Feline (Cat)	Number in group:	2
(Other Species):		Number affected:	1
Breed :	DMH	Number vaccinated:	2
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	11 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Indoor only; received routine vacines (rabies, FVRCP, FELV); patient has another cat, no masses seen.			

#### Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	NV
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) XXX-XXX-XXXX
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	(b)(6)

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6)
*Today's Date:	01/18/2007 (MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 01/18/2007

Verified:yes

Reviewed:yes

Date Entered: 02/21/2007

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

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 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07138

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A600199A	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	22	02/10/2007
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/10/2007
Concurrent Drugs or Procedures:	

## Event Information

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
Explain the event and any treatment in a concise paragraph: Lymphadenopathy - Retropharyngeal LN	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	12 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	Just diagnosed

**Animal Information**

Case Identification: Conor	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1	
(Other Species):	Number affected: 1	
Breed: Kerry Blue Terrier	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos): 5 yrs 5 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Family Pet; Coyote spotted in area past 3 days		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	CO
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (XXX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6)
*Today's Date:	
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian

Other:

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/13/2007

Verified:yes

Reviewed:yes

Date Entered: 02/21/2007

CVB Reporter:

Acknowledgement:

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 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07155

Product Code: 14P5.20 4637.20 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Galaxy CV	165A	205211	<input checked="" type="checkbox"/> Viral
2 Galaxy DA2PPvL	165A	213343B	<input checked="" type="checkbox"/> Combination
3 Rabdomun	189	A602636	<input checked="" type="checkbox"/> Viral
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	25	03/07/2007
2 1 ml	SQ	R shoulder	25	03/07/2007
3 1 ml	SQ	R rear	25	03/07/2007
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use: (MM/DD/YYYY)	03/07/2007
Concurrent Drugs or Procedures:	vaccines only

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Both dogs presented for annual vaccines - came back within 1 hr w/urticaria & hives. Given benadryl IM 1mg/#IM low dose dexamethasone. 2 hrs later 1 dog was swelling again - dex IV @ 1mg/#. Emergency clinic 9 hrs later (after oral benadryl) for continued swelling. Next morning sleeping but no continued swelling, mildly pruritic.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	2 dogs from same litter

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 2	
(Other Species):	Number affected: 2	
Breed: Boston Terrier	Number vaccinated: 2	
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 6 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Routine up to date vaccines - no known history if lept vaccine previously administered (3 yr Rv + DHPPC had been given).		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State	FL
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) (XXX-XXXX)
FA			
E-mail		E-mail	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)
*Today's Date:	08/06/2007 (mm/dd/yyyy)

Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 03/08/2007

Verified:yes

Reviewed:yes

Date Entered: 04/13/2007

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07166

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 1	189	A591149B	<input checked="" type="checkbox"/> Viral
2			
3			
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml		R hind		
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/02/2007
Concurrent Drugs or Procedures:	none

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: licking paws, jumping, running around, couldn't get comfortable, vomited x1.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Not Listed
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)		Number in group: 1
(Other Species):		Number affected: 1
Breed: Shetland Shephard		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male		Number dead: 0
Neutered: <input checked="" type="checkbox"/> Not Listed		
Age (i.e., 2 yrs or 2 mos): 8 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): overall state of health was good.		

**Personal Information**

<b>Veterinarian</b>		<b>Owner</b>	
*Name	(b)(6)	Name	(b)(6)
Address		Address:	
City	(b)(6)	City:	
State		State:	
Zip		Zip:	
*Phone		Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Not Listed
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	
*Today's Date:	02/07/2007(MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 03/15/2007

Verified:yes

Reviewed:yes

Date Entered: 04/13/2007

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07188

Product Code: 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabdomun 1	189	S603745B	<input checked="" type="checkbox"/> Viral
2			
3			
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hind	22	11/01/2007
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/14/2007
Concurrent Drugs or Procedures:	None

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: within 1 hour of receiving vaccine started vomiting & was wobbly & weak.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?) (Include Units:mins, hrs, days, wks, mos, yrs)	within 1 hr
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)		Number in group: 1
(Other Species):		Number affected: 1
Breed: Pug		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male		Number dead: 0
Neutered: <input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos): 4.5 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): vaccination		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name:	(b)(6)
Address	(b)(6)	Address:	(b)(6)
City	(b)(6)	City:	(b)(6)
State	(b)(6)	State:	PA
Zip	(b)(6)	Zip:	(b)(6)
*Phone	(b)(6)	Phone:	(XXX-XXX-XXXX)
FAX	(b)(6)		
E-mail	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)
*Today's Date:	03/15/2007 (MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Veterinarian
Other:

[Submit](#)

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 03/26/2007

Verified:yes

Reviewed:yes

Date Entered: 05/02/2007

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07211

Product Code: 1905.24

\* Required Fields

## Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor I	189	A580480B	<input checked="" type="checkbox"/> Viral
2			
3			
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				04/27/2006
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use: (MM/DD/YYYY)	04/27/2006
Concurrent Drugs or Procedures:	HW/parasite screen - negative

## Event Information

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
----------------------	---

Explain the event and any treatment in a concise paragraph:  
 27 April 2006 vaccination healthy 3-5 days later coughing. 5-7 days later post-vac shortness of breath. Took dalmation to emergency hospital. Called Fairmont Animal Hospital, diagnosed with congestive heart failure. Sonigram & medications. Died 11 Dec 2006. cardiologist from cornell recommended medication. Bailey; choc lab

(12 yrs) throwing up, respiration strained. Died march 12, 2007, a month post-vacc symptoms started.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3-5 days post vacc
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Not Listed
*Outcome (select one):	<input checked="" type="checkbox"/> Died
Other:	

**Animal Information**

Case Identification:	Bailey & Max	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:2
(Other Species):		Number affected:2
Breed :	Chocolate Lab	Number vaccinated:2
Sex:	<input checked="" type="checkbox"/> Male	Number dead:2
Neutered:	<input checked="" type="checkbox"/> Not Listed	
Age (i.e., 2 yrs or 2 mos):	11.5 yrs & 12 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Fairmont Animal Hospital did not feel it was from vaccination. Patient ref # 0122395 & 00387002. Could not find Balwin Bell Emergency Hospital, vet clinic as listed on the report.		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address:	
City	(b)(6)	City	(b)(6)
State		State:	NY
Zip		Zip	(b)(6)
*Phon		Phone	(b)(6) XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Not Listed
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)

*Submitter's Phone Number:	(b)(6) XX-XXX-XXXX
*Today's Date:	04/10/2007(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/10/2007

Verified:yes

Reviewed:yes

Date Entered: 05/02/2007

CVB Reporter: BCoyle

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07225

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabdomun 1	189	S603745C	<input checked="" type="checkbox"/> Viral
2			
3			
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	IM	R left		
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use: (MM/DD/YYYY)	04/26/2007
Concurrent Drugs or Procedures:	microchip

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: within minutes rubbing at injection site, becoming weak, pale. Tx: epinephrine, dexamethasone, benedryl, IV fluids	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	<5 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	Rusty	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:1
(Other Species):		Number affected:1
Breed:	Shih Tzu	Number vaccinated:1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:0
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	4 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): 3rd rabies vaccination. no previous problems, in good health, no known allergies.		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address:	
City	(b)(6)	City:	
State		State:	
Zip		Zip:	
*Phone	(b)(6)	Phone	(b)(6) (XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)
*Today's Date:	04/27/2007(MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/27/2007

Verified:yes

Reviewed:yes

Date Entered: 05/02/2007

CVB Reporter: Frana

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07226

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 1	189	S606113	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

### Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hind	25	11/01/2007
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/27/2007
Concurrent Drugs or Procedures:	Exam, 4DX test

### Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: The owner called the next day and reported that within hours after the vaccine the dog developed vomiting and hives/swollen muzzle	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?):	hours
(Include Units: mins, hrs, days, wks, mos, yrs)	
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

**Animal Information**

Case Identification:	Tasha Theodorakakos	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1	
(Other Species):		Number affected: 1	
Breed:	Maltese	Number vaccinated: 1	
Sex:	<input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	7 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Pet, routine life, routine housing and diet			

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	NY
Zip	(b)(6)	Zip:	(b)(6)
*Phone	(b)(6)	Phone:	(b)(6) -XXX-XXXX
FA			
E-mail		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)
*Today's Date:	04/30/2007(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/30/2007

Verified:yes

Reviewed:yes

Date Entered: 05/02/2007

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07236

Product Code: 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	S605047E	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1ml	SQ	R flank	25	11/01/2007
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use: (MM/DD/YYYY)	05/04/2007
Concurrent Drugs or Procedures:	Exam, fecal centrifugation and 4DX test

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vomiting and Hives within 4-6 hours post-vaccine	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	4-6 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification: Gidget	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Bichon Frise	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos): 4.5 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Pet, routine diet and environment	

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State	NY
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) (XX-XXX-XXXX)
FA			
E-mail		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)
*Today's Date:	05/04/2007 (MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Veterinarian
Other: _____

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/04/2007

Verified:yes

Reviewed:yes

Date Entered: 05/21/2007

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07237

Product Code: 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	S606113	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1ml	SQ	L thigh	25	11/01/2007
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/30/2007
Concurrent Drugs or Procedures:	None

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vomiting which progressively worsened over 2-3 days post-vaccine	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	not listed
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	Rudy	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:1	
(Other Species):		Number affected:1	
Breed :	Miniature Dachsund	Number vaccinated:1	
Sex:	<input checked="" type="checkbox"/> Male	Number dead:0	
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	7.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Routine pet, indoor dog, routine diet and environment			

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	NY
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) (X-XXX-XXXX)
FA			
E-mail		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)
*Today's Date:	05/04/2007 (MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/04/2007

Verified:yes

Reviewed:yes

Date Entered: 05/21/2007

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07243

Product Code: 13D1.22 1905.24 14P5.20

\* Required Fields

## Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard Plus 5	189	A606869B	<input checked="" type="checkbox"/> Viral
2 Defensor 1	189	S604793E	<input checked="" type="checkbox"/> Bacterial
3 Vanguard CV	189	A607698C	<input checked="" type="checkbox"/> Viral
4			<input checked="" type="checkbox"/> [Click arrow for selections]

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ		22	03/08/2007
2 1 ml	SQ		22	03/08/2007
3 1 ml	SQ		22	03/08/2007
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/08/2007
Concurrent Drugs or Procedures:	adult wellness testing (normal) and rimadyl (NSAID) 75 mg q24h

## Event Information

* Event description:	<input checked="" type="checkbox"/> Autoimmune
Explain the event and any treatment in a concise paragraph: presented 5/7/2007 for pale gums, elevated WBC and anemia. owner said was also exposed to weed killer week before	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2 mos
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	owner has not picked up prednisone/doxycycline as of yet

**Animal Information**

Case Identification:	17286-4	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	2
(Other Species):		Number affected:	1
Breed:	Labrador Retriever	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	11 yrs & 11 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): 2 dogs in household, both ate treated grass, other dog was vaccinated on 5/8/07, offered purina dog food, bloodtesting every 6 months has been normal, last dental cleaning 1/2006			

**Personal Information**

<b>Veterinarian</b>			
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address:	
City	(b)(6)	City:	
State	(b)(6)	State:	
Zip	(b)(6)	Zip:	
*Phone	(b)(6)	Phone:	(XXX-XXX-XXXX)
FAX	(b)(6)		
E-mail	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)

*Submitter's Phone Number	(b)(6)
*Today's Date:	05/09/2007(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/09/2007

Verified:yes

Reviewed:yes

Date Entered: 05/21/2007

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07250  
 Product Code: 1905.24 13D1.29

\* Required Fields  
 Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	S606114	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916165A	<input checked="" type="checkbox"/> Viral
3			
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R rear		
2 1 ml	SQ	Dorsal shoulder		
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/30/2007
Concurrent Drugs or Procedures:	None

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: facial swelling. Tx: Dex SP, Benedryl IM	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	4 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification: Scooter	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1	
(Other Species):	Number affected: 1	
Breed: Daschund	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 1.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): In good health, no previous rx.		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:		Address:	
City:	(b)(6)	City:	
State:		State:	
Zip:		Zip:	
*Phone:		Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	
*Today's Date:	05/14/2007 (MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/14/2007

Verified:yes

Reviewed:yes

Date Entered: 05/21/2007

CVB Reporter: Frana

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07251

Product Code: 1905.24 18M1.29

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	S606114	<input checked="" type="checkbox"/> Viral
2 Duramune Max Pv	112	1658104B	<input checked="" type="checkbox"/> Viral
3			
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R rear		
2 1 ml	SQ	Dorsal shoulder		
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/11/2007
Concurrent Drugs or Procedures:	None

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: facial swelling, dex sp, benedryl IM	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2-3 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	Maggie	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	King Cavalier Spaniel	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos):	5 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): in good health, no previous			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:	(b)(6)	City:	
State:		State:	
Zip:		Zip:	
*Phone:	(b)(6)	Phone:	(b)(6) XXX-XXX-XXXX
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6)
*Today's Date:	05/14/2007 (MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/14/2007

Verified:yes

Reviewed:yes

Date Entered: 05/21/2007

CVB Reporter: Frana

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07287

Product Code: 1555.21 16E1.20 1905.24

\* Required Fields

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Feline Leukemia	189		<input checked="" type="checkbox"/> Viral
2 Felocell 4	189		<input checked="" type="checkbox"/> Viral
3 Rabies	189		<input checked="" type="checkbox"/> Viral
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/27/2002
Concurrent Drugs or Procedures:	

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Neoplasia/Cancer
----------------------	--

Explain the event and any treatment in a concise paragraph:  
 Initial reaction developed within weeks - high fever over 105 degrees. cate developed stupor and could not walk. After treatment from other vets, cat recovered. Large fibersarcoma or injection site sarcoma vas/iss diagnosed on 3/17/05. Cate died on 4/26/06 after 1 yr of treatment. Prior to vas diagnosis cat would periodically vomit bile -

Improved after surgery.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): weeks to years  
(Include Units: mins, hrs, days, wks, mos, yrs)

Attending veterinarian's level of suspicion that product caused event:  High

\*Outcome (select one):  Died

Other:

### Animal Information

Case Identification:	Pookie	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Feline (Cat)	Number in group: 1
(Other Species):		Number affected: 1
Breed:	Maine Coon	Number vaccinated: 1
Sex:	<input checked="" type="checkbox"/> Male	Number dead: 0
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	4 yrs 8 mos	

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Indoor cat, owner since cat was 3 weeks old. One companion cat, DSH, vaccinated same day - no reaction. Pet seen regularly as recommended by vet.

### Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	CO
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (XXX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	(b)(6)

This event has been reported to the manufacturer(s):  Yes

\*Submitter's First Name: (b)(6)

\*Submitter's Last Name: (b)(6)

*Submitter's Phone Number	(b)(6)	(X-XXX-XXXX)
*Today's Date:	04/22/2007(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> Owner	
Other:		

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/20/2007

Verified:yes

Reviewed:yes

Date Entered: 06/15/2007

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07305

Product Code: 13D1.29 2668.00 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Max 5	112	916184A	<input checked="" type="checkbox"/> Viral
2 Leptovax 4	112	350222A	<input checked="" type="checkbox"/> Bacterial
3 Defensor 3	189	S605047E	<input checked="" type="checkbox"/> Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	IM	Rear end		
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/01/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Systemic
----------------------	--

Explain the event and any treatment in a concise paragraph:  
 came to clinic as a pre-screen for teeth cleaning. vaccinated & took blood. owner said dog really struggled during blood collection. After vaccine was given dog "never was right again". Held head down, stopped eating. took to emergency clinic on may 5, 2007 - dexamethasone & prednisone along with tracedone given better until steroid given

on may 29. Nystagmus described by owner on may 5. May 29 took back to same emergency clinic - gave injection of des & tables of dex. June 4th severe panting. back to emerg. clinic, took xrays & scripted chloramphenicol june 5 dog died. Emergency vet never gave diagnosis of vaccine related issue. Owner said no diagnosis or prognosis was given to her.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Low
*Outcome (select one):	<input checked="" type="checkbox"/> Died
Other:	

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Bishon	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male	Number dead: 1
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos): approx 9 yrs	

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):  
skin allergies, a year before dog had trouble with back legs, disc problem? Dr. Heywood treated with steroids & he got better.

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State: PA	
Zip	(b)(6)	Zip:	(b)(6)
*Phone	(b)(6)	Phone:	(b)(6) (XX-XXX-XXXX)
FA			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
--	--

*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(XXX-XXX-XXXX)
*Today's Date:	06/07/2007(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/07/2007

Verified:yes

Reviewed:yes

Date Entered: 07/11/2007

CVB Reporter: Huls

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07316

Product Code: 13C1.20 18M1.23 1905.24 2100.02

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard DA2P	189	A612719	<input checked="" type="checkbox"/> Viral
2 Vanguard plus CPV	189	A714324	<input checked="" type="checkbox"/> Viral
3 Defensor 3	189	S606114	<input checked="" type="checkbox"/> Viral
4 Bronchicine CAe	189	A610888	<input checked="" type="checkbox"/> Bacterial

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	22	06/26/2007
2 1 ml	SQ	L shoulder	22	06/26/2007
3 1 ml	SQ	L hip	22	06/26/2007
4 1 ml	SQ	R hip	22	06/26/2007

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/26/2007
Concurrent Drugs or Procedures:	none

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Moderate muzzle and periocular swelling. Dex SP 4mg/ml 0.5mg/kg IV and Benadryl 50mg/ml 4mg/kg IM. Swelling reduced by 75% in 6 hours. Pet vomited once but contained plastic so unlikely related to the vaccine reaction. Puppy placed on LRS plus 5% dextrose as a precaution.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30-60 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	10391	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Mini Dachshund	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos):	4 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:		Address:	
City:		City:	
State:		State:	
Zip:		Zip:	
*Phone:		Phone: (XXX-XXX-XXXX)	
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	
*Submitter's Phone Number:	

*Today's Date:	06/26/2007(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/26/2007

Verified:yes

Reviewed:yes

Date Entered: 07/11/2007

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07326

Product Code: 16D1.20 1555.21 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A611807B	<input checked="" type="checkbox"/> Viral
2 Leukocell 2	189	A602401	<input checked="" type="checkbox"/> Viral
3 Defensor 1	189	S610805	<input checked="" type="checkbox"/> Viral
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ			
2	SQ			
3	SQ			
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/18/2007
Concurrent Drugs or Procedures:	none

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: fever, anorexia, lethargy began after vacc & continued to 12 hours post vaccination. Hospitalized for fluid therapy & NSAID to reduce fever (104).	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	5 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Not Listed
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	none

**Animal Information**

Case Identification:	Tigger	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	not listed	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Not Listed		
Age (i.e., 2 yrs or 2 mos):	9 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): no illness at time of vaccination; no pre-existing allergies, birth defects or medical conditions.			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	FL
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) XXX-XXX-XXXX
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6)
*Today's Date:	

Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/26/2007

Verified: yes

Reviewed: yes

Date Entered: 07/11/2007

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07327

Product Code: 16D1.20 1555.21 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Fellocell 3	189	A611808B	<input checked="" type="checkbox"/> Viral
2 Leukocell 2	189	A602401	<input checked="" type="checkbox"/> Viral
3 Defensor 1	189	S610805	<input checked="" type="checkbox"/> Viral
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ			
2	SQ			
3	SQ			
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/14/2007
Concurrent Drugs or Procedures:	none

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: owner reported lethargy in the evening the same date as vaccination. presented the following a.m. with fever (104), lethargy, anorexia. treated with fluid therapy & NSAIDS	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?):	6 hrs (Include Units:mins, hrs, days, wks, mos, yrs)
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Not Listed
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	Phoebe	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Feline (Cat)	Number in group: 1
(Other Species):		Number affected: 1
Breed:	not listed	Number vaccinated: 1
Sex:	<input checked="" type="checkbox"/> Female	Number dead: 0
Neutered:	<input checked="" type="checkbox"/> Not Listed	
Age (i.e., 2 yrs or 2 mos):	3 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): no illness at time of vaccination & no pre-existing allergies, birth defects, or medical conditions.		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	FL
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (XX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	(b)(6)

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6)
*Today's Date:	06/20/2007 (mm/dd/yyyy)

Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/26/2007

Verified:yes

Reviewed:yes

Date Entered: 07/11/2007

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07333

Product Code: 13D1.29 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Max 5	112	916207A	<input checked="" type="checkbox"/> Viral
2 Defensor	189	S604793C	<input checked="" type="checkbox"/> Viral
3			
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R scapular	22	07/05/2007
2 1 ml	SQ	R rear leg	23	07/05/2007
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/05/2007
Concurrent Drugs or Procedures:	routine vaccination

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: very painful at site of injection	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 day
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)		Number in group: 1
(Other Species):		Number affected: 1
Breed: Lab		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male		Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 1 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Single pet household, history of ear problems. Other than that no health concerns.		

**Personal Information**

<b>Veterinarian</b>		<b>Owner</b>	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	IL
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(XXX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)
*Today's Date:	07/09/2007 (MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/09/2007

Verified:yes

Reviewed:yes

Date Entered: 08/28/2007

CVB Reporter: .

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07343  
 Product Code: 1905.24 1331.20

\* Required Fields  
 Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S606115A	
2 Continuum DAP	286	90067001A	
3			
4			

### Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hind		
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/19/2007
Concurrent Drugs or Procedures:	physical exam, H.W. test

### Event Information.

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: hives, facial swelling, Tx: diphenhydramine	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	313562 "Bell"	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Rat Terrier	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	3.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): in good health, no known previous reactions			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:	(b)(6)	City:	
State:		State:	
Zip:		Zip:	
*Phone:		Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	
*Today's Date:	07/23/2007 (MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/23/2007

Verified:yes

Reviewed:yes

Date Entered: 08/28/2007

CVB Reporter: Frana

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07344

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S606115A	
2			
3			
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hind		
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/20/2007
Concurrent Drugs or Procedures:	physical exam, H.W. test

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Tx: diphenhydramine	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	313 471 "Wendy"	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):		Number affected: 1
Breed:	Boston Terrier	Number vaccinated: 1
Sex:	<input checked="" type="checkbox"/> Female	Number dead: 0
Neutered:	<input checked="" type="checkbox"/> No	
Age (i.e., 2 yrs or 2 mos):	3 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): In good health, no previous Rx		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:	(b)(6)	City:	
State:		State:	
Zip:		Zip:	
*Phone:		Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	
*Today's Date:	07/23/2007 (MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/23/2007

Verified:yes

Reviewed:yes

Date Entered: 08/28/2007

CVB Reporter: Frana

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07353

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	S606670	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	unknown	unknown	unknown	
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/11/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: Area of hyperpigmentation/alopecis over shoulderblades. Biopsy revealed vaccine induced ischemic dermatopathy	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	approx. 2 mos
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	Starting treatment

**Animal Information**

Case Identification:	1958	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):		Number affected: 1
Breed:	Pomeranian	Number vaccinated: 1
Sex:	<input checked="" type="checkbox"/> Female	Number dead: 0
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	5 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Animal was vaccinated at a low cost vaccination program held at Veterinary Health Center at 305 N. Center, Saginaw, MI		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	MI
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (X-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6)
*Today's Date:	07/27/2007(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian

Other:

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/27/2007

Verified:yes

Reviewed:yes

Date Entered: 08/28/2007

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. <p><a href="http://www.aphis.usda.gov/vs/cvb/lc/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV07365  
 Product Code: 16D1.22 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Fel-O-Guard Plus 3	112	117159A	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	S606113	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/17/2007
Concurrent Drugs or Procedures:	

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: death - anaphylaxis	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): minutes (Include Units:mins, hrs, days, wks, mos, yrs)	
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Died
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Feline (Cat)		Number in group: 1
(Other Species):		Number affected: 1
Breed:		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female		Number dead: 1
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 5		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	IN
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) XX-XXX-XXXX
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	(b)(6)

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) XX-XXX-XXXX
*Today's Date:	08/02/2007(MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 08/02/2007

Verified:yes

Reviewed:yes

Date Entered: 08/28/2007

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/fic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08036

Product Code: 1905.24 13D1.22

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	1718014	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A607874B	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ			
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/17/2007
Concurrent Drugs or Procedures:	

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: facial swelling	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1	
(Other Species):	Number affected: 1	
Breed: Dachshund	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:		Address:	
City:		City:	
State:		State:	
Zip:		Zip:	
*Phone:		Phone: (XXX-XXX-XXXX)	
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	
*Submitter's Phone Number:	
*Today's Date:	09/21/2007 (MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/21/2007

Verified:yes

Reviewed:yes

Date Entered: 10/09/2007

CVB Reporter: Osorio

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08098

Product Code: 2668.00 1331.20 1905.24 1081.00

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune LCI/GP	112	045127A	<input checked="" type="checkbox"/> Bacterial
2 Continuum DAP	286	90066003B	<input checked="" type="checkbox"/> Viral
3 Defensor 3	189	S716100	<input checked="" type="checkbox"/> Viral
4 Bronchi-Shield	112	110249C	<input checked="" type="checkbox"/> Bacterial

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L rear leg	25	
2 1 ml	SQ	R fore leg	25	12/05/2007
3 1 ml	SQ	R rear leg	25	
4 1 ml	IN	nasal	NA	12/05/2007

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	12/05/2007
Concurrent Drugs or Procedures:	none

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Following visit, patient vomited in the lobby (about 5 mins post vax). Physical exam revealed pale mucous membranes, tachycardia and thready pulses. An IV catheter was placed. The patient was given dexamethasone SP IV, benadryl IM and IV fluids.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	approx. 5 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):	Number affected:	1
Breed: Poodle Mix	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Male	Number dead:	0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): not given		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Owned for 1 year, obtained from rescue. History of intermittent itchiness. Indoor only. Commercial dry diet.		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	GA
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) XXX-XXX-XXXX
FA	(b)(6)		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) XXX-XXXX

*Today's Date:	12/13/2007(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 12/13/2007

Verified:yes

Reviewed:yes

Date Entered: 01/23/2008

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08130

Product Code: 1905.24 1561.23 16C1.22

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A585925B	<input checked="" type="checkbox"/> Viral
2 Feline Ultranasal FPL Vaccine	213	4529	<input checked="" type="checkbox"/> Viral
3 Feline Ultranasal FVRC Vaccine	213	4438	<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	06/10/2006
2 0.2 ml	IN	nares	none	06/10/2006
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/10/2006
Concurrent Drugs or Procedures:	FeLV/FIV test, and microchip.

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: Vomiting, anorexia, lethargy. Gave 17.5mg Benadryl SQ, and 2.5mg famotidine PO.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Feline (Cat)		Number in group: 1
(Other Species):		Number affected: 1
Breed: Bengal		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female		Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 3 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Indoor only. No significant medical problems.		

**Personal Information**

<b>Veterinarian</b>			
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	MI
Zip	(b)(6)	Zip:	(b)(6)
*Phone	(b)(6)	Phone:	(b)(6) (XX-XXX-XXXX)
FA			
E-mail		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)
*Today's Date:	07/09/2008(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Other
Other: Licensed Veterinary Technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 01/09/2008

Verified: yes

Reviewed: yes

Date Entered: 01/23/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08173

Product Code: 47K1.20 1905.24 14P5.20

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard Plus 5 L4	189	A715191A	<input checked="" type="checkbox"/> Combination
2 Defensor 3	189	S714887D	<input checked="" type="checkbox"/> Viral
3 Vanguard CV	189	A713530C	<input checked="" type="checkbox"/> Combination
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R scapula	25	02/04/2007
2 1 ml	SQ	R hip	22	11/01/2008
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/04/2008
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
----------------------	--

Explain the event and any treatment in a concise paragraph:  
 Approximately 15 minutes after vaccines were administered, pup became very quiet, then vomited. MM were pale/gray, HR 72 bpm. Gave 4mg Dex SP SQ and 7.5mg diphenhydramine IM. Observed pup for approximately 20 minutes - once activity level improved and mucous membranes gained some normal color, pup was discharged. 8

days later, pup has a localized reaction at the site of the Vanguard 5CV/L4

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	15 mins/ 1 week
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification: Blaze	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):	Number affected:	1
Breed: Shiba Inu	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Male	Number dead:	0
Neutered: <input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos): 4 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Previous distemper vaccines did not contain leptospirosis - no adverse events with those vaccines. No other animals in household. Owner obtained approximately 2 months prior to event		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	IL
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) (XX-XXX-XXXX)
FA			
E-mail		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6) (-XXXX)

*Submitter's Phone Number:	
*Today's Date:	02/12/2008(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/12/2008

Verified:yes

Reviewed:yes

Date Entered: 02/22/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08178

Product Code: 1555.21 1905.24 15B5.20 15B5.20

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A602401	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	A470300B	<input checked="" type="checkbox"/> Viral
3 Fel-O-Vac Lv-K III	112	219128A	<input checked="" type="checkbox"/> Viral
4 Fel-O-Vac Lv-K III	112	219126A	<input checked="" type="checkbox"/> Viral

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L rear leg	22	03/30/2007
2 1 ml	SQ	R rear leg	22	04/30/2005
3 1 ml	SQ	L rear leg	22	04/30/2005
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/30/2007
Concurrent Drugs or Procedures:	

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
----------------------	---

Explain the event and any treatment in a concise paragraph:  
 Radiographs 12/27/07 for L rear leg lameness, radiographs revealed disuse atrophy of L rear leg. Metacam inj SQ, Buprenex sent home for oral use. 1/12/08 1lb wt loss since 12/27/07, not eating, lethargy, very painful L rear leg, much muscle atrophy of limb, cat hold foot in unnatural curled under position. Radiographs reveal increased density

of soft tissue caudal totibia. Blood pressure 115. Fine needle aspirates done.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?) (Include Units:mins, hrs, days, wks, mos, yrs)	9 mos
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Did not recover
Other:	Euthanized 1/30/08

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Feline (Cat)		Number in group: 1
(Other Species):		Number affected: 1
Breed: DSH		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female		Number dead: 1
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 11 yrs 9 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Found as a stray 3/96. Linear foreign body 2/2000 surgically removed. Linear foreign body & sewing needle removed 11/2001. Routine annual exams 2002, 2003, 2004, 2005, 2007. vaccines given each year.		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	OR
Zip	(b)(6)	Zip:	(b)(6)
*Phone	(b)(6)	Phone:	(b)(6) (X-XXX-XXXX)
FA			
E-mail		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)

*Submitter's Phone Number	(b)(6)	XX-XXXX
*Today's Date:	02/05/2008(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian	
Other:		

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/12/2008

Verified:yes

Reviewed:yes

Date Entered: 02/22/2008

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08187

Product Code: 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A585925B	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	05/24/2006
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/24/2006
Concurrent Drugs or Procedures:	FeLV/FIV test and Bartonella test.

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: Lethargy and tenderness. No treatment.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	24 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Feline (Cat)	Number in group: 1
(Other Species):	Number affected: 1
Breed: DSH	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos): 3 yrs	

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):  
History of struvite urinary crystals, eats Eukanuba Low pH-S canned food. No other medical history and no past vaccine reactions.

**Personal Information**

Veterinarian	Owner
*Name: Christina Boud...	Name: (b)(6)
Address: (b)(6)	Address: (b)(6)
City: (b)(6)	City: (b)(6)
State: (b)(6)	State: MI
Zip: (b)(6)	Zip: (b)(6)
*Phone: (b)(6)	Phone: (b)(6) (X-XXX-XXXX)
FAX: (b)(6)	
E-mail: (b)(6)	E-mail: (b)(6)

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) (XXX)
*Today's Date:	02/02/2008(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	Licensed Veterinary Technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/02/2008

Verified:yes

Reviewed:yes

Date Entered: 02/22/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08191  
 Product Code: 1905.24 16D1.22

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A246970	<input checked="" type="checkbox"/> Viral
2 Trivalent FVRCP	213	HF-188-051A	<input checked="" type="checkbox"/> Combination
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	06/02/2003
2 1 ml	IN/IO	nares/eyes	none	06/02/2003
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/02/2003
Concurrent Drugs or Procedures:	None

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Found pea-sized lump RR leg from rabies vaccine. ~20mm x 15mm x 10mm - firm nodule. Took FNA. Came back as localized inflammation probably from vaccine. Elect to monitor for changes. Lump resolved by next visit (1 year later).	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units: mins, hrs, days, wks, mos, yrs)	15 days
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Feline (Cat)	Number in group:	1
(Other Species):	Number affected:	1
Breed: DMH	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Female	Number dead:	0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	5 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Indoor only. No significant medical history.		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	MI
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) (XXX-XXX-XXXX)
FA			
E-mail		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) (XX-XXXX)

*Today's Date:	02/02/2008(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	Licensed Veterinary Technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/02/2008

Verified:yes

Reviewed:yes

Date Entered: 02/22/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08209

Product Code: 1081.00 1905.24 13D1.22

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard B (IN)	112	110251B	<input checked="" type="checkbox"/> Bacterial
2 Defensor 3	189	S715662D	<input checked="" type="checkbox"/> Viral
3 Vanguard Plus 5	189	A716645C	<input checked="" type="checkbox"/> Viral
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	IN	nostrils		02/21/2008
2 1 ml	SQ	R hind thigh	22	02/21/2008
3 1 ml	SQ	R shoulder	22	02/21/2008
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/21/2008
Concurrent Drugs or Procedures:	physical exam and expressed anal glands. On Sentinel also

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Swollen face.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	11328	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:1
(Other Species):		Number affected:1
Breed:	Bichon Frise	Number vaccinated:1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:0
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	1 yrs 2 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Acquired from breeder 2/9/07; has had all puppy shots, no vaccine reactions; eats Royal Canin Adult Dry.		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	IWA
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (X-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	rosebud820@yahoo.com

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) (XX-XXXX)
*Today's Date:	02/27/2008 (MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/27/2008

Verified:yes

Reviewed:yes

Date Entered: 03/26/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08210

Product Code: 1081.00 13D1.22 1905.24

\* Required Fields

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard B (IN)	112	110251B	<input checked="" type="checkbox"/> Bacterial
2 Vanguard Plus 5	189	A716645C	<input checked="" type="checkbox"/> Viral
3 Defensor 3	189	S715662D	<input checked="" type="checkbox"/> Viral
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	IN	nostrils		02/18/2008
2 1 ml	SQ	R shoulder	22	02/18/2008
3 1 ml	SQ	R hind thigh	22	02/18/2008
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/18/2008
Concurrent Drugs or Procedures:	physical exam

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: vomited 4x in exam room and mm were pale, and dog became lethargic, was very active prior to receiving all 3 vaccines	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	13110	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:1
(Other Species):		Number affected:1
Breed:	Pug	Number vaccinated:1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:0
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	1 yrs. 11 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): puppy vaccines done 1/17/07 at another vet clinic. eats nutro adult dry food, no medications currently including flea/hw meds, no medical problems in past except reverse sneeze when excited.		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	WA
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (XX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) (X-XXXX)

*Today's Date: 02/27/2008(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/27/2008

Verified: yes

Reviewed: yes

Date Entered: 03/26/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08220

Product Code: 1331.20 1905.24

\* Required Fields

## Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Adult 3	112	1867104A	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	S605047E	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L shoulder	22	02/29/2008
2 1 ml	SQ	R hind	22	02/29/2008
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/29/2008
Concurrent Drugs or Procedures:	none

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Developed edematous facial swelling, especially around muzzle. Also a few small hives on the top of her head.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	45 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	Abby	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Chihuahua	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs 3 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	MA
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(XXX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) (XXX)
*Today's Date:	(b)(6)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/29/2008

Verified:yes

Reviewed:yes

Date Entered: 03/27/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08260

Product Code: 1905.24 13D1.29 14M1.20

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S715663C	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916218A	<input checked="" type="checkbox"/> Viral
3 Kennel-Jec-2	124	544A	<input checked="" type="checkbox"/> Combination
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	23	04/10/2008
2 1 ml	SQ	L shoulder	22	04/10/2008
3 1 ml	IN	Nose		04/10/2008
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/10/2008
Concurrent Drugs or Procedures:	

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: 4/10/08 premedicated with 3 mg dexamethasone IV vacc. within 30 mins acute vomiting pallor & pruritis face.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)		Number in group: 1
(Other Species):		Number affected: 1
Breed: Lhasa/Bichon		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female		Number dead: 0
Neutered: <input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos): 11 yrs 6 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Has had previous vaccination reactions but not when premedicated. 4/10/08 premedicated with 3 mg dexamethasone IV vacc. within 30 mins acute vomiting pallor & pruritis face.		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	IL
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (XX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6)
*Today's Date:	04/10/2008(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/17/2008

Verified:yes

Reviewed:yes

Date Entered: 04/23/2008

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08266

Product Code: 1905.24 13D1.22

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S716099A	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A722370A	<input checked="" type="checkbox"/> Viral
3			
4			

### Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ			
2 1 ml	SQ			
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/26/2008
Concurrent Drugs or Procedures:	none

### Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
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Explain the event and any treatment in a concise paragraph:  
 Anaphylaxis: vomited bile, became weak in rear limbs then collapsed, pale mucous membranes, bradycardia, progressively obtunded. Over the ensuing 15 minutes responded to dexamethasone SP6 mg/IM, Diphenhydramine 6 mg IM, epinephrine 1:1000 0.8 ml IV, bolus 150 ml LRS IV. Monitored in hospital for 3 hours and discharged bright,

alert and wagging tail. Subsequent follow-up calls found the dog perfectly normal per owner. Dog had bad dose of each vaccine given about a year earlier.

<p align="center">If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.</p>	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	5-10 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):	Number affected:	1
Breed: Lhaso Apso	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Female	Number dead:	0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	17 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:	(b)(6)	City:	
State:		State:	
Zip:		Zip:	
*Phone:		Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Not Listed
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)

*Submitter's Phone Number	(b)(6)	(X-XXXX)
*Today's Date:	04/18/2008(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian	
Other:		

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/18/2008

Verified:yes

Reviewed:yes

Date Entered: 04/28/2008

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08349

Product Code: 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S717854B	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RH leg	25	06/11/2008
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/11/2008
Concurrent Drugs or Procedures:	blooddraw for heartworm test

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vomited two times about 20 minutes after the vaccine. Collapsed, weak, pale/gray mucous membranes. Place IV catheter gave bolus of fluids and perked up. Kept hospitalized on fluids remainder of the day.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	20 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	Bruno	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1	
(Other Species):		Number affected: 1	
Breed:	Yorkshire Terrier	Number vaccinated: 1	
Sex:	<input checked="" type="checkbox"/> Male	Number dead: 0	
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	9 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Has had 4 rabies vaccines in the past with no known reactions.			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:	(b)(6)	City:	
State:		State:	
Zip:		Zip:	
*Phone:		Phone:	(XXX-XXX-XXXX)
FA:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) XXXXX
*Today's Date:	00/12/2008(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/12/2008

Verified:yes

Reviewed:yes

Date Entered: 07/22/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08366

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S720867E	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ			
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/01/2008
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: on and off vomiting and lethargy	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification: Pet ID 23355	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Australian Shepherd Mix	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos): 3 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):	

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:		Address:	
City:		City:	
State:		State:	
Zip:		Zip:	
*Phone:		Phone: (XXX-XXX-XXXX)	
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	
*Submitter's Phone Number:	
*Today's Date:	07/08/2008(MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Other
Other:	Practice manager of hospital

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/08/2008

Verified:yes

Reviewed:yes

Date Entered: 08/07/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08383

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S720866A	<input checked="" type="checkbox"/> Viral
2			
3			
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	22	07/15/2008
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/15/2008
Concurrent Drugs or Procedures:	none

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: vomited on the way home, then became dizzy and dazed. vomited at home and on the way back to the clinic. on arrival mucous membranes were pale, patient was ataxic & tachypneic (?).	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Mini Schnauzer	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos): 5 yrs	

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):  
 acquired from reputable breeder in California, vaccinated against infectious diseases in a timely manner. Pet is cared for impeccably by wonderful "parents".

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State	WA
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) (X-XXX-XXXX)
FA			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) (XXX)

*Today's Date: 07/18/2008(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/18/2008

Verified: yes

Reviewed: yes

Date Entered: 08/28/2008

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08397

Product Code: 1905.21 1905.24 1905.20

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabvac 3	112	1215280A	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	A473673	<input checked="" type="checkbox"/> Viral
3 Imrab 3	298	12467	<input checked="" type="checkbox"/> Viral
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1				01/13/2007
2				10/08/2005
3				09/28/2004
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/13/2007
Concurrent Drugs or Procedures:	

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Neoplasia/Cancer
----------------------	--

Explain the event and any treatment in a concise paragraph:  
 Sherman developed a mass caudal to the stifle in the right rear leg. The leg was removed with coxo-femoral disarticulation and the mass was biopsied. It was found to be a fibrosarcoma. (see attached report).

Note: the last rabies vaccine administered was Code 1905.21, Serial 1215280A, manufactured by 112.

<p>If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.</p>	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 yrs 2 mos after the last vax in that leg
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	no evidence of metastasis or local spread at this time.

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Feline (Cat)	Number in group:	1
(Other Species):	Number affected:	1
Breed: DSH	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Male	Number dead:	0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): see attached records		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	WA
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) XXX-XXX-XXXX
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	(b)(6)
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)

*Submitter's Phone Number	(b)(6) X-XXXX
*Today's Date:	05/05/2008(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit:

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/06/2008

Verified:yes

Reviewed:yes

Date Entered: 08/28/2008

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08418

Product Code: 1905.24

\* Required Fields

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S723029C	<input checked="" type="checkbox"/> Viral
2			
3			
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Dorsom shoulder	20	07/22/2008
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/22/2008
Concurrent Drugs or Procedures:	none

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: Acute lameness in rear limb. Bella was given a routine rabies vaccination for travelling to Canada and to issue a health certificate. Within hours she was non-weight bearing on a rear limb and on reexamination on 7/23/08 (within 24 hours) she would put very little weight on it.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	24 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

### Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):	Number affected:	1
Breed: Retriever Mix	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Female	Number dead:	0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	5 yrs 2 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

### Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	OR
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) XXX-XXX-XXXX
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	vmhughes@comcast.net

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) XX-XXX-XXXX

*Today's Date: 08/14/2008(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 08/25/2008

Verified: yes

Reviewed: yes

Date Entered: 09/22/2008

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV08448

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabdomun	189	S721691	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

### Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml		hind leg		
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use: (MM/DD/YYYY)	8/11/08
Concurrent Drugs or Procedures:	

### Event Information

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
Explain the event and any treatment in a concise paragraph: Rabies shot	
ROC: 9/18/08 called vet for event info, will call back this afternoon	

ROC 9/25/08: Dr. Ueckert shared clinical records with me via telephone. Vaccine was administered on 8/11/08. Owner brought back to clinic on 9/4/08 and exam revealed lameness. Dx was arthritis and was tx with anti-inflammatories. On 9/8/08 owner requested dog be euthanized.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 days
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Low
*Outcome (select one):	<input checked="" type="checkbox"/> Did not recover
Other:	

### Animal Information

Case Identification:	Killer	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Min Pin	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	7 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

### Personal Information

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	TX
Zip	(b)(6)	Zip:	(b)(6)
*Phone	(b)(6)	Phone:	(b)(6) (XX-XXX-XXXX)
FA			
E-mail	(b)(6)	E-mail:	(b)(6)

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)

*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) (XXX-XXX-XXXX)
*Today's Date:	09/07/2008(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/07/2008

Verified:yes

Reviewed:yes

Date Entered: 09/30/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09018

Product Code: 13D1.22 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard Plus 3	189	8721903691	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	8721900908	<input checked="" type="checkbox"/> Viral
3			
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Between shoulders	24	09/16/2008
2 1 ml	SQ	L hip	24	09/16/2008
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/16/2008
Concurrent Drugs or Procedures:	

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: dog was given rabies & distemper - adenovirus type 2 - parainfluenza - parvovirus vaccines, had a reaction 1 hour later, treated with .15 benedryl IV & 1 ml dexamethasone 1 m will split up vaccines in future.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 hr
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)		Number in group: 1
(Other Species):		Number affected: 1
Breed: Shihtzu/Bechon		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male		Number dead: 0
Neutered: <input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos): 4 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): 1st distemper given at 8 wks by breeder, 2nd distemper given by south fork vet at 12 wks on 8/16/08. distemper & rabies given at southfork at 16 wks on 9/16/08.		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State: MN	
Zip	(b)(6)	Zip:	(b)(6)
*Phone	(b)(6)	Phone:	(b)(6) XXX-XXX-XXXX
FA			
E-mail		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Not Listed
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) -XXXX

*Today's Date:	09/18/2008(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/22/2008

Verified:yes

Reviewed:yes

Date Entered: 11/18/2008

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

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 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09030

Product Code: 16E5.23 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Fel-O-Vax IV + CaliciVax	112	1841104A	<input checked="" type="checkbox"/> Combination
2 Defensor 3	189	S829084A	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

### Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L rear	22	10/13/2008
2 1 ml	SQ	R rear	22	10/13/2008
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/13/2008
Concurrent Drugs or Procedures:	none

### Event Information

* Event description:	<input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: patient became lethargic, febrile and anorexic with mild diarrhea within 12-24 hours post-vaccine.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	<24 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	Pending treatment

**Animal Information**

Case Identification:	Duncan Fournier	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Feline (Cat)	Number in group: 1
(Other Species):		Number affected: 1
Breed:	DLH	Number vaccinated: 1
Sex:	<input checked="" type="checkbox"/> Male	Number dead: 0
Neutered:	<input checked="" type="checkbox"/> No	
Age (i.e., 2 yrs or 2 mos):	6 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Indoor only. One previous FvRCPC vaccine in 6/08.		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State	TX
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) (XX-XXX-XXXX)
FA			
E-mail	(b)(6)	E-mail	(b)(6)
This event has been reported to the manufacturer(s):		<input checked="" type="checkbox"/> No	
*Submitter's First Name	(b)(6)		
*Submitter's Last Name	(b)(6)		
*Submitter's Phone Number	(b)(6)		(XX)
*Today's Date:	10/14/2008 (MM/DD/YYYY)		
Relationship to animal:			

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/14/2008

Verified:yes

Reviewed:yes

Date Entered: 11/18/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

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 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09031

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	1479285	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RH leg	22	
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/07/2005
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	<input checked="" type="checkbox"/> Autoimmune
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Explain the event and any treatment in a concise paragraph:  
 Kimmie received a rabies vaccine. She was lethargic over the next 7 days. She was taken to a vet and diagnosed with Addisons disease. She was not treated for Addisons until she had a second Addisons crisis 3 months later. She then did OK until 6 months later. She presented with icterus/anemia and was euthanized. (see attached letter with

hard copy)

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 day
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	eventually 1 yrs later euthanized

### Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)
Kimmie	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Mix	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos): 10 yrs	

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):  
Kimmie was diagnosed with Addisons disease one week after having received a rabies vaccine. She was managed and treated for Addisons for 1 year. At that time she was euthanized due to anemia and jaundice of undetermined etiology.

### Personal Information

Veterinarian		Owner	
*Name:		Name:	
Address:		Address:	(b)(6)
City:		City:	
State:	(b)(6)	State:	NY
Zip:		Zip:	(b)(6)
*Phone:		Phone:	(b)(6) X-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Not Listed
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	

*Submitter's Phone Number	(b)(6)	X-XXX-XXXX
*Today's Date:	10/13/2008(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> Owner	
Other:		

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/13/2008

Verified:yes

Reviewed:yes

Date Entered: 12/09/2008

CVB Reporter: Osorio

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09032  
 Product Code: 13D1.29 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Max 5	112	916310A	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	S724038	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF leg	22	10/14/2008
2 1 ml	SQ	RR leg	22	11/01/2008
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/14/2008
Concurrent Drugs or Procedures:	ear cleaning with MalAcetic Otic, and application of Otomax to R ear

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Puppy was vx'd in exam room after exam client and puppy went up to lobby to check out. Puppy Vomited 2 large piles and became very lethargic. Tech took puppy and owner back in exam room and notified vet. Vet admin. 32 mg	

benadryl IM and 1 mg Dex SQ. Sent puppy home for monitoring throughout day.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	15 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	12789	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Lab	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos):	18 wks		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): 3rd DAPP vx, 1st RV at time of occurrence			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:	(b)(6)	City:	
State:	(b)(6)	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6)	Phone:	(XXX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
	(XXX-XXX-XXXX)

*Submitter's Phone Number:	
*Today's Date:	10/14/2008(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	LVT

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/14/2008

Verified:yes

Reviewed:yes

Date Entered: 12/09/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09037

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S720288	<input checked="" type="checkbox"/> Viral
2			
3			
4			

### Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RH leg	25	
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/14/2008
Concurrent Drugs or Procedures:	nail trim, exam

### Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: vomited on way home	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units: mins, hrs, days, wks, mos, yrs)	20 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	9915	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Mini Dachhund	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos):	4 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): from breeder who is a vet			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	MA
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (XX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) (X-XXX-XXXX)
*Today's Date:	10/20/2008(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Veterinarian
Other:

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/20/2008

Verified:yes

Reviewed:yes

Date Entered: 12/09/2008

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09041

Product Code: 1905.24 13D1.22 1081.00 2126.R0

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S724896D	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A829624	<input checked="" type="checkbox"/> Viral
3 Bronchi-Shield	112	110257B	<input checked="" type="checkbox"/> Bacterial
4 Recombitek Lyme	298	42135	<input checked="" type="checkbox"/> Recombinant

### Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR hip	22	10/08/2008
2 1 ml	SQ	L lumbar	22	10/08/2008
3 1 ml	IN	Nostrils	n/a	10/08/2008
4 1 ml	SQ	LR hip	22	10/08/2008

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/08/2008
Concurrent Drugs or Procedures:	no

### Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vomiting uncontrollably, could barely walk. Vomited apr. 12-13 times in a matter of a couple hours. Patient also had a bowel movement in the house.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?):	hrs
(Include Units:mins, hrs, days, wks, mos, yrs)	
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	26365 "Tucker"	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Medium Mix	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos):	2 yrs & 2 days		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	TX
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone:	(XXX-XXX-XXXX)
FA	(b)(6)		
E-mail	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) (XX-XXXX)
*Today's Date:	10/22/2008 (MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	Technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/22/2008

Verified:yes

Reviewed:yes

Date Entered: 12/09/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. <p><a href="http://www.aphis.usda.gov/vs/cvb/lc/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09042

Product Code: 1905.24 13D1.22 1081.00

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S724896D	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A827725B	<input checked="" type="checkbox"/> Viral
3 Bronchi-Shield	112	110256B	<input checked="" type="checkbox"/> Bacterial
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR hip	22	08/05/2008
2 1 ml	SQ	L lumbar	22	08/05/2008
3 1 ml	IN	Nostrils	n/a	08/05/2008
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/05/2008
Concurrent Drugs or Procedures:	no

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Facial swelling, very itchy and had a red abdomen	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?):hrs (Include Units:mins, hrs, days, wks, mos, yrs)	
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	13210	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:1
(Other Species):		Number affected:1
Breed:	Dachshund	Number vaccinated:1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:0
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	6 yrs & 6 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	TX
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(XXX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) X-XXXX
*Today's Date:	10/22/2008(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Not Listed
--

Other: Technician
-------------------

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/22/2008

Verified:yes

Reviewed:yes

Date Entered: 12/09/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09050

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S719552A	<input checked="" type="checkbox"/> Viral
2			
3			
4			

### Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RH leg	22	
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/29/2008
Concurrent Drugs or Procedures:	none

### Event Information

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
Explain the event and any treatment in a concise paragraph: 12/9/2008 ROC: I called Dr. Haims about this case. He said that the dog was presented to him on 4/19/08 and determined that the dogs was in kidney failure. The dog died the next day 4/20/08. He does not suspect the vaccine is associated with this case.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	not given
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Low
*Outcome (select one):	<input checked="" type="checkbox"/> Died
Other:	

**Animal Information**

Case Identification:	Titdie	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Pit Mix	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	1
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	7 yrs 2 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	NY
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) X-XXX-XXXX
FA	(b)(6)		
E-mail	(b)(6)	E-mail	(b)(6)

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Not Listed
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) XX-XXX-XXXX

*Today's Date:	10/31/2008(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/31/2008

Verified:yes

Reviewed:yes

Date Entered: 12/09/2008

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09061

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S826915A	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF	22	10/24/2008
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/24/2008
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: nystagmus circling	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	15 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:		<b>For animals handled in a group (herd, litter, etc.)</b>
*Species: <input checked="" type="checkbox"/> Feline (Cat)		Number in group: 1
(Other Species):		Number affected: 1
Breed: DSH		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female		Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 18 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): hasn't been vaccinated for many years		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:	(b)(6)	City:	
State:	(b)(6)	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6)	Phone:	(XXX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)-XXX-XXXX
*Today's Date:	11/10/2008(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Other
Other: Vet Tech

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/10/2008

Verified: yes

Reviewed: yes

Date Entered: 01/02/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09066

Product Code: 2668.00 13D1.22 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard L4	189	A826181	<input checked="" type="checkbox"/> Bacterial
2 Vanguard Plus 5	189	A828276B	<input checked="" type="checkbox"/> Viral
3 Defensor 1	189	S829085D	<input checked="" type="checkbox"/> Viral
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L lateral neck	22	11/17/2008
2 1 ml	SQ	L lateral neck	22	11/17/2008
3 1 ml	SQ	R lateral neck	22	11/17/2008
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/17/2008
Concurrent Drugs or Procedures:	

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: vaccines given about 3:30 p.m. owner took dog to emergency clinic at 8 p.m. for vomiting and rubbing face.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	5 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)		Number in group:1
(Other Species):		Number affected:1
Breed: Mini Schnauzer		Number vaccinated:1
Sex: <input checked="" type="checkbox"/> Female		Number dead:0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):2 yrs 7 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

<b>Veterinarian</b>		<b>Owner</b>	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	TX
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (XX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	(b)(6)

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) (XX)
*Today's Date:	11/18/2008(MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/18/2008

Verified:yes

Reviewed:yes

Date Entered: 01/02/2009

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09067

Product Code: 13D1.29 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Max 5	112	916310A	<input checked="" type="checkbox"/> Viral
2 Defensor 1	189	S725738	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

### Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ		22	11/06/2008
2 1 ml	SQ	RR	22	
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/06/2008
Concurrent Drugs or Procedures:	none

### Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Four hours post-vaccination the dog vomited once and had diarrhea twice. The dog was slightly lethargic. Diphenhydramine and Dexamethosone were administered via SQ injection. The dog seemed fine after that.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	4 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)		Number in group: 1
(Other Species):		Number affected: 1
Breed: Chiweenie		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male		Number dead: 0
Neutered: <input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos): 18 wks		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): New puppy from pet store		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:	(b)(6)	City:	
State:	(b)(6)	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6)	Phone: (XXX-XXX-XXXX)	
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) (-XXXX)
*Today's Date:	11/18/2008(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	LVT

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/18/2008

Verified:yes

Reviewed:yes

Date Entered: 01/02/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09069

Product Code: 1905.24 13D1.22 108100 2126.R0

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S724896D	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A829624	<input checked="" type="checkbox"/> Viral
3 Bronch-Shield	112	110259A	<input checked="" type="checkbox"/> Bacterial
4 Recombitek Lyme	298	42135	<input checked="" type="checkbox"/> Recombinant

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	22	11/06/2008
2 1 ml	SQ	L lumbar	22	11/06/2008
3 0.5 mls	IN	Nostrils	n/a	11/06/2008
4 1 ml	SQ	LR	22	11/06/2008

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/06/2008
Concurrent Drugs or Procedures:	no

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vomited several times following her vaccines and lethargy.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

**Animal Information**

Case Identification:	20986 "Precious"	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Dachhund Mix	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	4 yrs & 8 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

**Personal Information**

<b>Veterinarian</b>		<b>Owner</b>	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	TX
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(XXX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) (XXX)
*Today's Date:	11/19/2008(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Other
Other: Technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/19/2008

Verified:yes

Reviewed:yes

Date Entered: 01/02/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09070

Product Code: 1905.24 13D1.22 1081.00

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S724896D	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A829624	<input checked="" type="checkbox"/> Viral
3 Bronchi-Shield	112	110259A	<input checked="" type="checkbox"/> Bacterial
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR hip	22	10/27/2008
2 1 ml	SQ	L lumbar	22	10/27/2008
3 0.5 mls	IN	Nostrils	n/a	10/27/2008
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/27/2008
Concurrent Drugs or Procedures:	no

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
Explain the event and any treatment in a concise paragraph: Patient began foaming @ the mouth, coughing and sneezing. Temperature of 103.7. Reactions started the day after vaccines.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	24 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	27585 "Patches"	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:1	
(Other Species):		Number affected:1	
Breed:	Japanese Chin	Number vaccinated:1	
Sex:	<input checked="" type="checkbox"/> Female	Number dead:0	
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs 6 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	TX
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(XXX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6)-XXXX
*Today's Date:	11/13/2000 (MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	Technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/19/2008

Verified:yes

Reviewed:yes

Date Entered: 01/02/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09078

Product Code: 13D1.29 1905.24 12X1.20

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Max 5	112	196329A	<input checked="" type="checkbox"/> Viral
2 Defensor 1	189	S724038	<input checked="" type="checkbox"/> Viral
3 Intra-Trac 3	165A	54172A	<input checked="" type="checkbox"/> Combination
4			<input checked="" type="checkbox"/> [Click arrow for selections]

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/26/2008
Concurrent Drugs or Procedures:	observe in clinic

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
----------------------	--

Explain the event and any treatment in a concise paragraph:  
 The vaccines were given and approximately 10 minutes later the dog vomited. Treatments Diphenhydramine 0.16ml and Dexamethasone 0.25ml were given and the dog was observed for about 25 minutes. Dog went home and another hour and 15 minutes later the dog had vomited more and was itching her face and had red nose and eyes as

well as slight facial swelling. Dog came back into hospital and we observed her for 4 hours, no concerns. Dog left with owner and vomited in vehicle so the dog came back in to the clinic. The dog vomited two more times and started pawing at face again and had red spots in one ear. Gave Diphenhydramine 0.29ml. Observed dog for 2 more hours. No signs noted.

<p>If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.</p>	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Not Listed
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):	Number affected:	1
Breed: Shih Tzu	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Female	Number dead:	0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs 8 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:		Address:	
City:		City:	
State:		State:	
Zip:		Zip:	
*Phone:		Phone: (XXX-XXX-XXXX)	
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Not Listed
--	--

*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)-XXXX-XXXX
*Today's Date:	11/26/2008 (MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Not Listed
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/26/2008

Verified:yes

Reviewed:yes

Date Entered: 01/02/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09081

Product Code: 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 1	189	S608371	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> Combination
3			<input checked="" type="checkbox"/> Combination
4			<input checked="" type="checkbox"/> Combination

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/18/2008
Concurrent Drugs or Procedures:	

## Event Information

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
Explain the event and any treatment in a concise paragraph: 30 minutes after event my cat could not stand up no treatment given by vet on return visit.  ROC: I talked to owner and she said that Veterinarian said that cat had diabetes & kidney failure prior to vaccination.	

Progressively got worse and died on 5/23/2008.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Not Listed
*Outcome (select one):	<input checked="" type="checkbox"/> Died
Other:	Died 5/23/2008

### Animal Information

Case Identification:	2008US35233	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Feline (Cat)	Number in group: 1
(Other Species):		Number affected: 1
Breed:	Siamese mix	Number vaccinated: 1
Sex:	<input checked="" type="checkbox"/> Female	Number dead: 1
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	16 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

### Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	MO
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (X-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6) (X-XXX-XXXX)

*Submitter's Phone Number:	
*Today's Date:	12/01/2008(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 12/01/2008

Verified:yes

Reviewed:yes

Date Entered: 01/02/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09086

Product Code: 13D1.20 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Galaxy DA2PPvL	165A	212350B	<input checked="" type="checkbox"/> Combination
2 Defensor 1	189	S826916A	<input checked="" type="checkbox"/> Viral
3			
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Intrascapular	22	11/21/2008
2 1 ml	SQ	Intrascapular	22	11/21/2008
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/21/2008
Concurrent Drugs or Procedures:	

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
----------------------	--

Explain the event and any treatment in a concise paragraph:  
 patient came in for vx appt 11/21 @ 10:10 a.m. owner called @ 5 p.m. reported patient had a swollen face & welts on body & patient was lethargic offered for owner to bring patient down now. owner couldn't bring patient in. patient was taken to emergency vet clinic @ 7:40 p.m. was given dexamethasone SP inj 6 mg IV & diphenhydramine inj 16

mg IM & swelling resolved.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): 6 hrs  
(Include Units: mins, hrs, days, wks, mos, yrs)

Attending veterinarian's level of suspicion that product caused event:  Not Listed

\*Outcome (select one):  Recovered with treatment

Other:

### Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)		Number in group: 1
(Other Species):		Number affected: 1
Breed: Pug		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female		Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 2 yrs 1 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

### Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	(b)(6)	State:	CA
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6)	Phone:	(b)(6) (XX-XXX-XXXX)
FAX:	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6) (X-XXX-XXXX)

*Submitter's Phone Number:	
*Today's Date:	11/28/2008(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	vet tech

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/28/2008

Verified:yes

Reviewed:yes

Date Entered: 02/20/2009

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/lc/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09088

Product Code: 16D1.20 16D1.20 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A827324C	<input checked="" type="checkbox"/> Viral
2 Felocell 3	189	A612496B	<input checked="" type="checkbox"/> Viral
3 Defensor 1	189	S714887C	<input checked="" type="checkbox"/> Viral
4			<input checked="" type="checkbox"/> [Click arrow for selections]

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	LL scapula	22	10/22/2008
2 1 ml	SQ	LL scapula	22	10/12/2008
3 1 ml	SQ	LR scapula	22	10/12/2008
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/22/2008
Concurrent Drugs or Procedures:	none

## Event Information

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
Explain the event and any treatment in a concise paragraph: The cat developed anorexia 5 days post vaccination. PE on 10/30/2008 revealed a severe ileus. Foreign body was suspected and an abdominal exploratory performed. Negative findings. Cat continued to decline despite aggressive intensive care she continued to decline and was euthanized on 11/02/2008.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	about 5 days
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Did not recover
Other:	

### Animal Information

Case Identification: Sidney	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Feline (Cat)	Number in group:	1
(Other Species):	Number affected:	1
Breed: DSH	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Female	Number dead:	0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 2 yrs 4 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): owner got her as a kitten, history of fractured leg when kitten, healed and no other health problems. 3 other cats in house are fine/healthy and up to date on vaccines. Indoor 100%		

### Personal Information

		<b>Owner</b>	
*Name:	(b)(6)	Name:	(b)(6)
Address:		Address:	
City:		City:	(b)(6)
State:		State:	CO
Zip:		Zip:	(b)(6)
*Phone:		Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	
*Submitter's Phone Number:	

*Today's Date:	12/10/2008(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian	
Other:		

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 12/10/2008

Verified:yes

Reviewed:yes

Date Entered: 02/20/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09114

Product Code: 4637.20 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Galaxy DA2PPvL	165A	213398A	<input checked="" type="checkbox"/> Combination
2 Defensor 1	189	S725737B	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	IM	LR leg		01/07/2009
2 1 ml	IM	R side leg		01/07/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/07/2009
Concurrent Drugs or Procedures:	dexamethasone injection

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: After the animal was vaccinated with serial 213398A, it developed a anaphylactic reaction that lasted approximately 24 hrs.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)		Number in group: 1
(Other Species):		Number affected: 1
Breed: Jack Russell Terrier		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female		Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 1 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:		Address:	
City:		City:	
State:		State: GA	
Zip:		Zip:	Zip:
*Phone:		*Phone:	(b)(6) (XX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	
*Submitter's Phone Number:	
*Today's Date:	01/08/2009 (MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other: Employee	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 01/08/2009

Verified: yes

Reviewed: yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09121

Product Code: 13D1.22 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard Plus 5	189	8721903691	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	8721900908	<input checked="" type="checkbox"/> Viral
3			
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Withers	25	01/03/2009
2 1 ml	SQ	hip	25	01/03/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/03/2009
Concurrent Drugs or Procedures:	

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Gave DHPP & rabies on 1/3/09. Later returned with swollen lips & eyelids. Gave 50 g diph & 6 mg dexamethasone. Dog recovered & is doing fine.	

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	not listed
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):		Number affected: 1
Breed:	Golden Retriever	Number vaccinated: 1
Sex:	<input checked="" type="checkbox"/> Female	Number dead: 0
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	9 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name:	(b)(6)
Address	(b)(6)	Address:	
City	(b)(6)	City:	
State	(b)(6)	State:	
Zip	(b)(6)	Zip:	
*Phone	(b)(6)	Phone:	(XXX-XXX-XXXX)
FA	(b)(6)		
E-mail:	(b)(6)	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Not Listed
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) XX
*Today's Date:	01/14/2009(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 01/20/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09143

Product Code: 47K1.20 14M1.20 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard Plus 5 L4	189	A829821C	<input checked="" type="checkbox"/> Combination
2 Intra-Trac II	165A	53655A	<input checked="" type="checkbox"/> Combination
3 Rabdomun 1	189	S829083	<input checked="" type="checkbox"/> Viral
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L lumbar	22	12/30/2008
2 1 ml	Intranasal	Nose		12/30/2008
3 1 ml	SQ	R lumbar	22	12/30/2008
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	12/30/2008
Concurrent Drugs or Procedures:	Solozone 0.3 mg daily

## Event Information

* Event description:	<input checked="" type="checkbox"/> Autoimmune
Explain the event and any treatment in a concise paragraph: Immune mediated hemolytic anemia and thrombocytopenia. treated with prednisone, azathioprine blood transfusions.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10 days
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Died
Other:	

**Animal Information**

Case Identification:		For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)		Number in group: 1
(Other Species):		Number affected: 1
Breed: Italian Greyhound		Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male		Number dead: 1
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 7 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State: MO	
Zip	(b)(6)	Zip:	(b)(6)
*Phone	(b)(6)	Phone:	(b)(6) XX-XXX-XXXX
FA			
E-mail		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6)
*Today's Date:	08/08/2008 (mm/dd/yyyy)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian

Other:

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/05/2009

Verified:yes

Reviewed:yes

Date Entered: 04/10/2009

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website. <p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>

# Adverse Event Report

Pharmacovigilance  
 United States Department of Agriculture  
 Center for Veterinary Biologics  
 510 South 17th Street, Suite 104  
 Ames, IA 50010  
 Phone: (515) 232-5785  
 FAX: (515) 232-7120

Record Number: AIV09144

Product Code: 1905.24 13D1.22 14P5.20

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S831726A	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A831191	<input checked="" type="checkbox"/> Viral
3 Vanguard CV	189	A831851A	<input checked="" type="checkbox"/> Viral
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	23	02/04/2009
2 1 ml	SQ	Intrascapular	23	02/04/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/04/2009
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: One episode of vomit and pale gums 30 minutes after administration. Hives about 3 hours after administration.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?) (Include Units: mins, hrs, days, wks, mos, yrs)	30 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	Glen	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1	
(Other Species):		Number affected: 1	
Breed:	Pug	Number vaccinated: 1	
Sex:	<input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Had 3 DHPPC as a puppy and 1 year Rabies on 1.25.08			

**Personal Information**

Veterinarian		Owner	
*Name	(b)(6)	Name	(b)(6)
Address	(b)(6)	Address	(b)(6)
City	(b)(6)	City	(b)(6)
State	(b)(6)	State:	WI
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:	sskif@bresnan.net	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) (XX)
*Today's Date:	02/05/2009 (MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/05/2009

Verified:yes

Reviewed:yes

Date Entered: 04/10/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p><a href="http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm">CVB Home Page</a>