

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: AIV09171

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	S831727B	<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				
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/06/2009
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:
 About 15 minutes after the injection, my pug began vomitting and had a glazed look in his eyes, treatment to counteract the reaction began immediately and continued for about a hour before he passed away, treatment included fluids, steroids, epinephrin, blood pressure monitoring and breathing monitoring, when he stopped breathing he was

intubated and cpr was administrated, treatment was ultimately unsuccessful

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"/> 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:	Pug	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):	3 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Generally healthy pug, did have seasonal allergies, never had a reaction to a vaccine in the past, this was his 3rd rabies vaccine, was fed California Natural Lamb & Rice (1 cup/day), lived in a townhome, indoor dog, was purchased from a breeder in Middleburg, PA		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	(b)(6)	Address	(b)(6)
City:		City	
State:	PA	State:	PA
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6) (-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	stephanie.piccini@gmail.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)	XXX-XXX-XXXX
*Today's Date:	03/01/2009(MM/DD/YYYY)	
Relationship to animal:	(b)(6)	
Other:		

Submit

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

Date Received: 03/01/2009

Verified:yes

Reviewed:yes

Date Entered: 04/21/2009

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>CVB Home Page

Adverse Event Report

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 United States Department of Agriculture
 Center for Veterinary Biologics
 510 South 17th Street, Suite 104
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 Phone: (515) 232-5785
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Record Number: AIV09175

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	S725738	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L shoulder	25	
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/06/2009
Concurrent Drugs or Procedures:	Ketamine, Diexapan, Isuflourene

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: Sever cutaneous vasculitis; slow onset, alopecia, dermal sloughing necrosis. 3.0 cm area over left scapula (circular) 3.0 cm X 12.9 cm area left lateral thorax and 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?): (Include Units:mins, hrs, days, wks, mos, yrs)	2 wks	
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:	current care	

Animal Information

Case Identification:	Riley	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 Pincher	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):	6 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:		City:	
State:	FL	State:	FL
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6) XXX-XXX-XXXX)	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) XXX-XXX-XXXX)
*Today's Date:	03/03/2009(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> (g)(q)
Other:	

Submit

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

Date Received: 03/03/2009

Verified:yes

Reviewed:yes

Date Entered: 04/21/2009

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>CVB Home Page

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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: AIV09179

Product Code: 1905.24 16E1.20

* 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	S608371	<input checked="" type="checkbox"/> Viral
2 Felocell 4	189	not given	<input checked="" type="checkbox"/> Combination
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ			
2 1 ml	IM or SQ			
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:	none

Event Information

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
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Explain the event and any treatment in a concise paragraph:
 My cats alleged 2 year rabies vaccination was due, which is all I wanted without my knowledge vet gave 4 other disease vaccines. I was not (at that time) a knowledgeable pet owner. I did not realize my cat had diabetes. I did not realize that she was lucky to survive all the harmful vaccines I had put into her during her life. The vet who will ??

gave my cat all the vaccines waited until after the shots to tell me how seriously ill she appeared - even showed me a picture of a cat with diabetes who could not stand. This occurred within 30-40 minutes after the shot. The vet did not offer any treatment - told me to get out before he charged me for another visit. He said she would die in 2 months and she did. He was very much aware of what he had done. Reid was aware of the adverse drug reaction before he even gave her the 2 shots.

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)	30-40 mins
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: Pooh	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:		City:	
State: MO		State: MO	
Zip:	(b)(6)	Zip:	(b)(6)
*Phone: (b)(6) XXX-XXX-XXXX		Phone: (b)(6) XXX-XXX-XXXX	
FAX:		FAX:	
E-mail:		E-mail:	

This event has been reported to	<input checked="" type="checkbox"/> Yes
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the manufacturer(s):	
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	(b)(6) XXX-XXX-XXXX
*Today's Date:	02/02/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> (b)(6)
Other:	

Submit

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

Date Received: 02/02/2009

Verified:yes

Reviewed:yes

Date Entered: 05/12/2009

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>CVB Home Page

Adverse Event Report

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 Phone: (515) 232-5785
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Record Number: AIV09190

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	S724897D	<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 leg	25	03/07/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/07/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: Firm subcutaneous nodule at vaccine site. Grew to about 3 cm (per owner). Decreased to 1 cm in size by 10 days later when pet was brought in for evaluation. No treatment necessary.	

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)	1-2 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:	(still resolving)

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:		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	(b)(6)
Address:	(b)(6)	Address	(b)(6)
City:		City:	
State:	CT	State:	CT
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6) XXX-XXX-XXXX	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) XX-XXX-XXXX
*Today's Date:	03/18/2009(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/>	(b)(4)
Other:		

Submit

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

Date Received: 03/18/2009

Verified:yes

Reviewed:yes

Date Entered: 05/12/2009

CVB Reporter:

Acknowledgement:

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

Record Number: AIV09222

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	S832530	<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				
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> [Click arrow for selections]
*Date of Product Use:(MM/DD/YYYY)	04/14/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: vomiting and facial swelling. Diphenhydramine Inj 50mg/ml, Dex Sodium Phos Inj 4mg/ml, Famotidine Inj 10mg/ml	
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 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"/> 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.):		

Personal Information

Veterinarian		Owner	
*Name:	(9)(a)	Name:	(9)(a)
Address:	(9)(a)	Address:	
City:		City:	
State:	CA	State:	
Zip:	(9)(a)	Zip:	(9)(a)
*Phone:	(9)(a) XXX-XXX-XXXX)	Phone:	(9)(a) 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:	(9)(a)
*Submitter's Last Name:	(9)(a)
*Submitter's Phone Number:	(9)(a) XXX-XXX-XXXX)
*Today's Date:	04/15/2009(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/>	(b) (4)
Other:	

Submit

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

Date Received: 04/15/2009

Verified:yes

Reviewed:yes

Date Entered: 06/15/2009

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>CVB Home Page

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: AIV09225

Product Code: 1905.24 16D5.20

* 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 1	189	S831727D	<input checked="" type="checkbox"/> Viral
2 Fel-O-Vax PCT	112	162325A	<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	R rear	25	04/11/2009
2 1 ml	SQ	R shoulder	25	04/11/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/11/2009
Concurrent Drugs or Procedures:	none

Event Information

* Event description: Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:

vomiting and collapse. Poor perfusion of capillaries. No initial response to benedryl and dexamethasone sp. Iv catheter placed and shock fluids run(LRS). Vomiting continues, high heart rate, epi sq given. Vomiting slows but blood present. Metoclopramide given after blood tinged vomit. Vomiting stopped and color and perfusion improved.

Cat went home after 5 hours.

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)	5-10 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"/> 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.): Indoor only. last vaccinated as young adult with eclipse 4(Sch/plough) and merial fvrpcp- mod. live		

Personal Information

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

*Submitter's Phone Number:	
*Today's Date:	04/16/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> (b) (9)
Other:	

Submit

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

Date Received: 04/16/2009

Verified:yes

Reviewed:yes

Date Entered: 06/19/2009

CVB Reporter:

Acknowledgement:

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

Record Number: AIV09260

Product Code: 1905.24 13D1.29 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 Defensor 1	189	S833963	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916393A	<input checked="" type="checkbox"/> Viral
3 Intra-Trac 3	165A	54190B	<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	RR		
2 1 ml	SQ	LR		
3	Intranasal	nares		
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/05/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vaccinations given at wellness exam, approximately 2 hours later moderate to severe facial swelling, especially the right side of face. Sophie also seem more lethargic on the car ride back to the clinic.	

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:	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):	1 yr 7 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State:	ND	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) XXX-XXX-XXXX	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	(b)(6) XXX-XXX-XXXX
*Today's Date:	05/05/2009(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	(b)(4)

Submit

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

Date Received: 05/05/2009

Verified:yes

Reviewed:yes

Date Entered: 08/04/2009

CVB Reporter:

Acknowledgement:

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

Record Number: AIV09281

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 lateral thigh		
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/16/2008
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Neoplasia/Cancer
Explain the event and any treatment in a concise paragraph: Quarter diameter X 1/2 cm firm, irregular, mass on right thigh - surgically removed 4/20/09; biopsy fibrosarcoma.	
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)	10-11 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:	final outcome pending

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

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State: NY		State:	
Zip:	(b)(6)	Zip:	
*Phone: (b)(6) XXX-XXX-XXXX		Phone: (XXX-XXX-XXXX)	
FAX:			
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-XXX-XXXX
*Today's Date:	05/18/2009(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/>	(b)(4)
Other:	

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

Date Received: 05/18/2009

Verified:yes

Reviewed:yes

Date Entered: 08/06/2009

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>CVB Home Page

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: AIV09288

Product Code: 13D1.20 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 Galaxy DA2PPvL	165A	212379B	<input checked="" type="checkbox"/> Viral
2 Intra-Trac II	165A	53659	<input checked="" type="checkbox"/> Combination
3 Defensor 1	189	S831726B	<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	LR	22	05/22/2009
2 1 ml	Intranasal	Nose	No needle	05/22/2009
3 1 ml	SQ	RR	22	05/22/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/22/2009
Concurrent Drugs or Procedures:	On Heartworm Medication

Event Information

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

Explain the event and any treatment in a concise paragraph:
 Patient presented for routine vaccinations. Vaccinations were administered on 5/22/09 at approx. 10:30 am. Patient then left the clinic and on the way home started to vomit and was lateral recumbent. Owners returned to the clinic around 11:00 am and patient presented with anaphylaxis. Set I.V catheter and administered Dexamethasone and

Benadryl, Administered fluids and observed.

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)	Roughly 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:	Bichon	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.):		

Personal Information

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

*Submitter's Phone Number:	
*Today's Date:	05/22/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Other
Other	(b)(4)

Submit

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

Date Received: 05/22/2009

Verified:yes

Reviewed:yes

Date Entered: 08/06/2009

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>CVB Home Page

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: AIV09302

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	S834806C	<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 shoulder	22	06/04/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/04/2009
Concurrent Drugs or Procedures:	Diphenhydramine 2 mg/kg IM

Event Information

* Event description: Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:

The dog was pre-treated with 2 mg/kg of diphenhydramine administered IM 30 minutes prior to vaccine administration due to the history of an adverse reaction to this same vaccine in 2006. The dog was observed in the hospital for almost 9 hours post-vaccine and briefly examined prior to being released to the owner. After the owner put the dog in

the car, it vomited and she brought the dog back into the building immediately. The dog was examined and no significant abnormalities were noted. The dog was then given 0.22 mg/kg dexamethasone and 1 mg/kg of maropitant by subcutaneous injection. Within 5 minutes the dog developed angioedema of the face and urticaria on the hind limbs and was pawing at his face. Diphenhydramine was then given at 2 mg/kg IM and the dog was observed for 20 minutes. He stopped pawing at the face and the swelling and hives did not worsen.

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 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: 2
(Other Species):	Number affected: 1
Breed: Miniature Pincher	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): 10 yrs	

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
 This dog has been vaccinated with Defensor 3 in 1999, 2000, and 2003 with no adverse events. He had a reaction to it in 2006 and again yesterday despite being pre-treated with diphenhydramine.

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State: AZ		State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) XX-XXX-XXXX	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)(4)
*Submitter's Last Name:	(b)(4)
*Submitter's Phone Number:	XXX-XXX-XXXX
*Today's Date:	06/05/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> (b)(4)
Other:	

Submit:

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

Date Received: 06/05/2009

Verified:yes

Reviewed:yes

Date Entered: 08/18/2009

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>CVB Home Page

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: AIV09334

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	S834803C	<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	11/01/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/20/2009
Concurrent Drugs or Procedures:	Timolol 0.5% ophth OS BID; Tacrolimus ophth OS BID

Event Information

* Event description: Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:

Approx 30 minutes after pt received Rabies vaccine, presented to hospital with labored breathing, very swollen face. Pt vomited twice. Was also very itchy, restless. Admin oxygen therapy, 2mg DexNaPhos 2mg IV, Diphenhydramine

20mg IV. Pt still swollen, itchy, restless. Placed IV catheter, bolused 150ml LRS IV over 15 minutes. Gave another 2mg DexNaPhos IV. Swelling decreased, breathing returned to normal. Pt still restless and itchy, but much less so.

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:	4699-1	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:	Pekingese	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):	15 yrs 8 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
 Client owned since puppy. No prev hx of vax reactions. Hx of anaphylaxis with PO Clindamycin 1/3/07. Environmental allergies. On Purina NF dry food. Received DHPPC vax on 8/19/08 with no problems. OD enucleation performed 6/13/07 due to perforated cornea.

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:		City:	
State:	CA	State:	CA
Zip:	92009	Zip:	(b)(6)
*Phone:	(b)(6) X-XXXX)	Phone:	(b)(6) X-XXX-XXXX)
FAX:	(b)(6)		
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:	XXX-XXX-XXXX
*Today's Date:	06/23/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	(b)(6)

Submit

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

Date Received: 06/23/2009

Verified:yes

Reviewed:yes

Date Entered: 09/17/2009

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>CVB Home Page

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: AIV09340

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	S835925B	<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	23	06/17/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/17/2009
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: Firm subcutaneous lump at injection site which owner noticed 9 days after vaccination date.	
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 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"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Silky 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): 4 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): From breeder in Missouri. DHPP vaccines on 3/23, 4/6, 4/29 and 5/22. Housed inside.	

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State: MT		State:	
Zip:		Zip:	
*Phone:	(b)(6) XXX-XXX-XXXX	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:	(b)(6) XXX-XXX-XXXX
*Today's Date:	07/02/2009(MM/DD/YYYY)
Relationship to animal:	

	☒	(b)(4)
Other:		

Submit

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

Date Received: 07/02/2009

Verified:yes

Reviewed:yes

Date Entered: 09/30/2009

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>CVB Home Page

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: AIV09353

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		<input checked="" type="checkbox"/> Viral
2			
3			
4			

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)	03/27/2009
Concurrent Drugs or Procedures:	

Event Information

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

Explain the event and any treatment in a concise paragraph:
 Patient was vaccinated around 9 a.m. Client returned with patient around 1 p.m., because patients eyes were swelling and there were bumps on the patients skin. Patients head was also shaking. Tx: patient was given 0.06 cc diphenhydramine (IM) and was monitored in hospital for approx 5 hrs. Recommended home care: Benadryl 25 mg,

1/6 tab orally every 8 hrs for 2 days.

<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)	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:	Lynch - 53092	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:	Chihuahua	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):	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:	(b)(6)	Address:	
City:		City:	
State:	TX	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) XXX-XXX-XXXX	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) XXX-XXX-XXXX

*Submitter's Phone Number:	
*Today's Date:	03/27/2009(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: 09/15/2009

Verified:yes

Reviewed:yes

Date Entered: 09/30/2009

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>CVB Home Page

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: AIV10026

Product Code: 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 Defensor 3	189	S830707	<input checked="" type="checkbox"/> Viral
2 Intra-Trac 3	165A	54195A	<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	RR leg	22	
2 1 ml	IN	L & R nostril		07/29/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/29/2009
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 0.19mL of diphenhydramine SQ approx. 10 min. before giving rabies vx SQ in right rear leg. Patient vomitted twice in clinic lobby. Client then took patient to e-clinic 5 hr later for muzzle edema and pruritis. E-clinic gave 2mg dexamethasone SP IM and told client to continue Benadryl q8h until swelling goes down.	

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?):	mins (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:		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 9 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Has had reactions to distemper vx in the past.		

Personal Information

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

*Today's Date:	07/30/2009(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: 07/30/2009

Verified:yes

Reviewed:yes

Date Entered: 12/08/2009

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. [CVB Home Page](http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm)

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: AIV10031

Product Code: 13D1.22 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 5 Plus	189	A839305B	<input checked="" type="checkbox"/> Viral
2 Defensor 1	189	S834806C	<input checked="" type="checkbox"/> Viral
3 Bronchicine	189	A939630A	<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	R shoulder	25	08/04/2009
2 1 ml	SQ	R hip	25	08/04/2009
3 1 ml	SQ	L shoulder	25	08/04/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/04/2009
Concurrent Drugs or Procedures:	

Event Information

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

Explain the event and any treatment in a concise paragraph:
 Within 5 minutes of vaccination, dog began vomiting, initially white foam followed by bile and dry heaving. Mucous membranes became pale. Dexamethasone sp 4mg was given intravenously, 5mg Diphenhydramine given IM, a 24 g IV Catheter was placed in the left cephalic and fluids administered at 50ml/hr. Mucous membrane color and capillary

refill time returned to normal within 10 minutes.

<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)	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:	0443-2 Shadow	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:	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):	1 yrs 3 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
 Owner obtained as puppy. He first presented to our clinic 7/11/08 at 10 weeks of age for routine health care. He was vaccinated for DHPPC and an intranasal Bordetella. On 8/4/08 he received a DHPPC and Bronchicine. On 8/21/08, he received a DHPPC and Defensor Rabies vaccination. He was neutered uneventfully and had normal pre-anesthetic bloodwork on 9/16/08. He received the Dental Vaccine manufactured by Pfizer on 8/21/08 and 9/16/08. He presented 8/4/09 for routine health care and booster vaccines. He had bloodwork drawn that day as part of a routine wellness panel performed by Antech Lab and all results were normal. He currently eats lams food and housed inside only.

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:		City:	
State:	MI	State:	MI
Zip:	(b)(6)	Zip:	(b)(6)
*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)(4)
*Submitter's Last Name:	(b)(4)
*Submitter's Phone Number:	XX-XXX-XXXX
*Today's Date:	08/05/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> (b)(4)
Other:	

Submit

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

Date Received: 08/05/2009

Verified:yes

Reviewed:yes

Date Entered: 12/11/2009

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>CVB Home Page

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: AIV10035

Product Code: 1905.24 13D1.29 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 Defensor 3	189	5830707	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916409A	<input checked="" type="checkbox"/> Viral
3 Intra-Trac III	165A	54196A	<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	RR leg	22	07/24/2009
2 1 ml	SQ	RF shoulder	22	07/24/2009
3 1 ml	IN	Nostrils	n/a	07/24/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/24/2009
Concurrent Drugs or Procedures:	n/a

Event Information

* Event description: Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:

After arriving home from doctor appointment, began vomiting, having diarrhea, and acting lethargic. Upon arrival at the clinic temp was 102.0, normal heart and respiratory rhythms. Evidence of diarrhea, no facial swelling or presence of hives. Administered 0.17mls diphenhydramine 50mg/ml IM in left caudal femoral region. Took home to monitor as

per owner.

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 hour
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:	12228	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"/> Male	Number dead:0
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	1 yrs 10 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:		City:	
State:	ND	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) XXX-XXX-XXXX	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)
	XXX-XXX-XXXX

*Submitter's Phone Number:	
*Today's Date:	08/06/2009(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: 08/06/2009

Verified:yes

Reviewed:yes

Date Entered: 12/11/2009

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>CVB Home Page

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: AIV10038

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	S835926C	<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	22	08/08/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/08/2009
Concurrent Drugs or Procedures:	None....wellness exam

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: patient acutely collapsed after administration. lost control of bowels. breathing fine, but mucous membranes pale. some improvement with diphenhydramine & dex	

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)	8-10 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	euthanized. radiographs performed d/t suspicion of ruptured HSA. large splenic mass.

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 :	Labrador	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):	13 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

Personal Information

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

*Today's Date: 08/10/2009(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> (b) (6)
Other:	

Submit

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

Date Received: 08/10/2009

Verified: yes

Reviewed: yes

Date Entered: 12/11/2009

CVB Reporter:

Acknowledgement:

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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: AIV10049

Product Code: 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 Defensor 3	189	S835926A	<input checked="" type="checkbox"/> Viral
2 Bronchicine CAe	189	A838376B	<input checked="" type="checkbox"/> Bacterial
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)	08/18/2008
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: Patient collapsed about 30-45 mins after the vaccines were given. Gums were gray, patient was panting and very lethargic. Placed patient on oxygen, gave an IM injection of diphenhydramine and suplingual epinephrine. Patient still very pale and lethargic. Placed pt on IV fluids with 5% dextrose. gave IV dex sp and famotidine - kept pt on IV fluids	

for 2 hours. patient back to normal the following morning.

<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)	30-45 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:	Flint - 53690	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):	5 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:	
Address:	(b)(6)	Address:	
City:		City:	
State:	TX	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) (XXX-XXX-XXXX)	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) (XXX-XXX-XXXX)

*Submitter's Phone Number:	
*Today's Date:	08/18/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Other
Other	(b)(4)

Submit

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

Date Received: 09/15/2009

Verified:yes

Reviewed:yes

Date Entered: 12/14/2009

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>CVB Home Page

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: AIV10051

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	S835926C	<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 leg	23	08/18/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/18/2009
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: 3 hours after vaccination hives and facial edema occurred.	
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 with treatment
Other:	

Animal Information

Case Identification:	Gus	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 :	Chihuahua	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):	6 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Indoors		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:		City:	(b)(6)
State:	MT	State:	MT
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) (-XXXX)	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	(b)(6) (XXX-XXX-XXXX)
*Today's Date:	08/19/2009(MM/DD/YYYY)
Relationship to animal:	

<input type="checkbox"/>	(b)(7)(D)
Other:	

Submit

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

Date Received: 08/19/2009

Verified:yes

Reviewed:yes

Date Entered: 12/14/2009

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>CVB Home Page

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: AIV10061

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	A830088	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	S835925B	<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	Intrascapular	22	06/17/2009
2 1 ml	SQ	RR leg	22	06/17/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/17/2009
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	<input checked="" type="checkbox"/> Autoimmune
Explain the event and any treatment in a concise paragraph: Severe, life threatening autoimmune thrombocytopenia, anemia and spontaneous hemorrhage. Multiple fresh whole blood transfusions, immunosuppressive Prednisone dosage orally and single Vincristine 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)	less than 65 days	
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:	Layla	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 Doodle	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):	6 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Acquired from breeder 4/13/09. Housed indoors. Had spirochete diarrhea on 4/20/09 and was treated with sulfasalazine 125mg twice daily for 5 days. Had DHPP vaccines on 4/15/09 by the breeder and by All West Vet on 5/6/09 and 5/27/09 and the vaccines listed above.			

Personal Information

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

*Today's Date:	08/28/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> (b)(1)
Other:	

Submit

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

Date Received: 08/28/2009

Verified:yes

Reviewed:yes

Date Entered: 12/22/2009

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>CVB Home Page

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: AIV10080

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	S835924A	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	25	09/17/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/17/2009
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: vomited 3 times within 3 minutes of vaccination and then once more 5 minutes later. Very pale mucous membranes, shocky	

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:	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 X	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.): Acquired by Animal Savers on 7/26/09. DHPP & Bordetella on 7/5/09, DHPP on 7/5/09, DHLPP and Bordetella on 8/18/09, DHLPP on 9/8/09, rabies 1 on 9/17/09.		

Personal Information

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

*Today's Date: 09/17/2009(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> (b)(4)
Other:	

Submit

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

Date Received: 09/18/2009

Verified: yes

Reviewed: yes

Date Entered: 01/15/2010

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. <http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm> CVB Home Page

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: AIV10097

Product Code: 1905.24 13D1.29 2100.02 46E5.21

* 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	S716078	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916261A	<input checked="" type="checkbox"/> Combination
3 Bronchicine CAe	189	A722080A	<input checked="" type="checkbox"/> [Click arrow for selections]
4 CvK/LCI-GP	112	094218A	<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)	04/17/2008
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: cysts formed where shots were administered, became crusty and bloody. Different vet gave steroids by injection, oral medication, and topical spray for treatments.	

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"/> 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: West Highland White 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): 16 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: OK		State: OK	
Zip:	(b)(6)	Zip:	(b)(6)
*Phone: (b)(6) (XX-XXX-XXXX)		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) (XX-XXX-XXXX)
*Today's Date:	04/20/2009(MM/DD/YYYY)

Relationship to animal:	<input type="checkbox"/>	(b)(9)
Other:		

Submit

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

Date Received: 04/20/2009

Verified:yes

Reviewed:yes

Date Entered: 01/19/2010

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>CVB Home Page

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: AIV10107

Product Code: 13D1.29 1905.24 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 Duramune Max 5	112	916462A	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	S82530	<input checked="" type="checkbox"/> Viral
3 Progard-KC	286	04089001A	<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	Intrascapular	25	11/01/2009
2 1 ml	SQ	Intrascapular	25	10/07/2009
3 0.5 ml	IN	L nostril	N/A	10/07/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/07/2009
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:
 Owner called within 30 min of appointment, patient's face was swollen. Patient presented within 1h of vaccination. Edema and erythema of lips/muzzle, periorbital. Treated with Dexamethasone SP 0.5mg/kg SC and diphenhydramine 0.5mg/kg IM. Decreased facial edema and erythema noted within 30 minutes; moderate

improvement within 1 hour; patient discharged to owner with instructions to monitor closely and present to emergency clinic if any concerns.

<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)	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:	Tank	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:	Siberian Husky	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):	2 yrs 3 mos		
<p>History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Previous vaccines as a puppy, no reactions known. Breeder told owner that a relative of this dog had died due to anaphylaxis of lept vaccine. Currently doing well. Indoor/outdoor pet. Diet: Pedigree dry + Alpo wet. Cryptorchid (inguinal, neutered at 9mo). Other dog in household vaccinated against bordetella, no problems noted.</p>			

Personal Information

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

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
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*Submitter's First Name:	Emi
*Submitter's Last Name:	Ludemann
*Submitter's Phone Number:	925-625-5330(XXX-XXX-XXXX)
*Today's Date:	10/07/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> (e)(q) <input type="checkbox"/>
Other:	

Submit

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

Date Received: 10/07/2009

Verified:yes

Reviewed:yes

Date Entered: 02/01/2010

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>CVB Home Page

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: AIV10114

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 3	112	117182C	<input checked="" type="checkbox"/> Viral
2 Rabdomun	189	S833627	<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	LR	22	10/13/2009
2 1 ml	SQ	RR	22	10/13/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/13/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: immediately after vaccinations were administered Kobey began profusely vomiting, developed generalized erythema, angioedema, and swelling of his extremities	

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)	Immediately
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: DMH		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 1 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State: ND		State:	
Zip:	(b)(6)	Zip:	
*Phone: (b)(6) XXX-XXX-XXXX		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	(b)(6) XXX-XXX-XXXX
*Today's Date:	10/13/2009(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other	(b) (4)

Submit

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

Date Received: 10/13/2009

Verified:yes

Reviewed:yes

Date Entered: 02/01/2010

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>CVB Home Page

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: AIV10115

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	1940351	<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	11/01/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/08/2009
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	<input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: Day after vaccine had redness/swelling in gums. Redness in both eyes. Lethargic. Coughing/labored breathing. Not eating/drinking.	

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"/> Canine (Dog)	Number in group: 0
(Other Species):	Number affected: 0
Breed: Labrador Mix	Number vaccinated: 0
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0
Neutered: <input checked="" type="checkbox"/> No	
Age (i.e., 2 yrs or 2 mos): 1 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Influenza and intestinal parasites as a puppy. No other health problems.	

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:		City:	
State: OH		State: OH	
Zip:	(b)(6)	Zip:	(b)(6)
*Phone: (b)(6) XXX)		Phone: (b)(6) XX-XXX-XXXX)	
FAX:			
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:	10/14/2009(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	(b) (4)

Submit

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

Date Received: 10/14/2009

Verified:yes

Reviewed:yes

Date Entered: 02/01/2010

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>CVB Home Page

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: AIV10124

Product Code: 2100.02 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 Bronchicine CAe	189	A832576B	<input checked="" type="checkbox"/> Bacterial
2 Vanguard Plus 5	189	A940425	<input checked="" type="checkbox"/> Viral
3 Defensor 3	189	S838775A	<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				
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/19/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vomiting, diarrhea	
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: 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):	1 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State:	AZ	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) (XXX-XXX-XXXX)	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	(b)(6) (XXX-XXX-XXXX)
*Today's Date:	10/20/2009(MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/>	(b)(9)	
Other:			

Submit

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

Date Received: 10/20/2009

Verified:yes

Reviewed:yes

Date Entered: 02/11/2010

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>CVB Home Page

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: AIV10129

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	213437A	<input checked="" type="checkbox"/> Combination
2 Rabdomun 1	189	S835928A	<input checked="" type="checkbox"/> Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml			22	10/23/2009
2 1 ml			22	
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/23/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Severe reaction/rushed to ER pet vet for exam & injection of 50 mg Diphenhy, VCA follow-up of 50 mg Bend. 3x times a day for 5 days.	

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: English Springer Spaniel		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.):		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:		City:	
State: IL		State: IL	
Zip:	(b)(6)	Zip:	(b)(6)
*Phone: (b)(6) XX-XXX-XXXX		Phone: (b)(6) XX-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:	10/26/2009(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/>	(b)(4)
Other:		

Submit

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

Date Received: 11/12/2009

Verified:yes

Reviewed:yes

Date Entered: 02/11/2010

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>CVB Home Page

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: AIV10133

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	5835925D	<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 thigh	22	10/30/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/30/2009
Concurrent Drugs or Procedures:	

Event Information

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

Explain the event and any treatment in a concise paragraph:
 My dog was given his 3 year rabies vaccine on 10/30/09. About 15 minutes after the vaccine, he started coughing and wheezing, and became lethargic. His entire body went limp, and he seemed to have difficulty breathing. I took him back to the vet because I knew something was very wrong. They examined him, and said his heart rate was up

from 80bpm (prior to vaccine) to 110bpm and his blood pressure was very low. His tongue turned a pale white. He had to be given Normasol-R at 10ml/hr via iv catheter, 2mg dexamethasone and .06 mg epinephrine were given intravenously. 5 hours after the reaction, I was able to pick him up and take him home. He has had rabies shots in the past with no adverse reaction. He has only had a negative reaction when given more than one shot at a time. The vet was told to only give him the required rabies 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)	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:	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: Schipperkee	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): 8 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
 I brought my dog home with me 9 years ago. He has lived with me in 4 apartments and one house. He has always been up to date on his vaccinations. In 2002, he was given his Rabies/Parvo/Lyme vaccination. He had an allergic reaction and had to be incubated and treated. Since that event, we have done tights and Rabies vaccinations with no issues. This is the first vaccination reaction he has had since 2002. He is otherwise very healthy, energetic, has a good appetite, sleeps well and is a great little guy. The only other allergic reaction I have ever seen with him is when I gave him a piece of a Perogi (potato based dumpling). I never gave him it again, as I assume there is an allergy there.

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	(b)(6)	Address	(b)(6)
City:		City	
State: DC		State: VA	
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6) XXX-XXX-XXXX)	Phone:	(b)(6) XX-XXX-XXXX)

FAX:202-965-3438	
E-mail:	E-mail:kweaver@caci.com

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	XX-XXX-XXXX
*Today's Date:	10/30/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> (b)(6)
Other:	

Submit

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

Date Received: 10/30/2009

Verified:yes

Reviewed:yes

Date Entered: 02/11/2010

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>CVB Home Page

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: AIV10143

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	S835927B	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

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

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/04/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: 9:32 given shots at home, reaction occurred nose swollen, ears red, eyes red, crying, hives on 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)	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:		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"/> Female		Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 16 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): health excellent, reaction to neither vaccine.		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:		City:	
State: FL		State: FL	
Zip:	(b)(6)	Zip:	(b)(6)
*Phone: (904) 229-4800 (XXX-XXX-XXXX)		Phone: (904) (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) (XXX-XXX-XXXX)
*Today's Date:	11/05/2009(MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/>	(b)(4)
Other:		

Submit

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

Date Received: 11/05/2009

Verified:yes

Reviewed:yes

Date Entered: 03/05/2010

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>CVB Home Page

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: AIV10146

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 1	189	S838996B	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A941345B	<input checked="" type="checkbox"/> Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip	22	10/31/2009
2 1 ml	SQ	R shoulder	22	10/31/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/31/2009
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: facial swelling & pruritis; dog returned with clinical signs x hours after visit.	
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?): x 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 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: Chi		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.): none		

Personal Information

Veterinarian		Owner	
*Name:	(b)(4)	Name:	(b)(4)
Address:	(b)(4)	Address:	(b)(4)
City:		City:	
State: MO		State: MO	
Zip:	(b)(4)	Zip:	(b)(4)
*Phone: (XXX-XXX-XXXX)		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)(4)
*Submitter's Last Name:	(b)(4)
*Submitter's Phone Number:	(XXX-XXX-XXXX)
*Today's Date:	11/09/2009(MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> (b)(4)
Other:	

Submit

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

Date Received: 11/09/2009

Verified:yes

Reviewed:yes

Date Entered: 03/05/2010

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>CVB Home Page

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: AIV10156

Product Code: 1905.24 47K1.20 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 Defensor 1	189	S837087C	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5 L4	189	A944438	<input checked="" type="checkbox"/> Viral
3 Bronchicine CAe	189	A942444C	<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	R hip	25	11/12/2009
2 1 ml	SQ	R shoulder	25	11/12/2009
3 1 ml	SQ	L shoulder	25	11/12/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/12/2009
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:
 pale mm, lethargic, ataxic. Presented within 15 minutes of injections. dog placed on O2, gave 10 mg diphenhydramine IV and 2.27 mg Dex SP IV. MM color minimally improved and BP difficult to read, tacky femoral pulses. Gave 0.1 ml Epinephrine IV, 1.8 mg Dex SP and 2.5 mg Diphenhydramine IV. Significant improvement--BP

140/85. Pink MM. Owner to give 12.5 mg Diphenhydramine q 8 hrs for 3 days.

<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)	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:	Juicy Wilson	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"/> Not Listed		
Age (i.e., 2 yrs or 2 mos):	1 yrs 4 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	(b)(7)(a)	Name:	
Address:	(b)(7)(a)	Address:	
City:		City:	
State:	DE	State:	
Zip:	(b)(7)(a)	Zip:	
*Phone:	(b)(7)(a) (XXX-XXX-XXXX)	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)(7)(a)
*Submitter's Last Name:	(b)(7)(a)
	(b)(7)(a) (XXX-XXX-XXXX)

*Submitter's Phone Number:	
*Today's Date:	11/16/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> (o)(q)
Other:	

Submit

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

Date Received: 11/16/2009

Verified:yes

Reviewed:yes

Date Entered: 03/10/2010

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>CVB Home Page

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: AIV10158

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	S838776D	<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)	11/16/2009
Concurrent Drugs or Procedures:	premed with 12.5 mg benadryl at home prior to vaccination

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: vomitting and diarrhea x 24 hours, mild muzzle swelling; treated next day with subcutaneous fluids, cerenia and DexSP	

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)	20-30 mins
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 treated this morning, anticipate recovery

Animal Information

Case Identification:	Fenway Paradise 9915	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"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> No		
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.): prev rabies vaccine 10/14/2008, similar vax reaction (reported 10/20/08)			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:	(b)(6)	City:	(b)(6)
State:	MA	State:	MA
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6) XXX-XXX-XXXX	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"/> Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) XXX-XXX-XXXX

*Today's Date: 11/17/2009(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> (b) (9)
Other:	

Submit

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

Date Received: 11/17/2009

Verified: yes

Reviewed: yes

Date Entered: 03/10/2010

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>CVB Home Page

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: AIV10162

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		<input checked="" type="checkbox"/> Viral
2			
3			
4			

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)	09/03/2008
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: 2 episodes vomiting over 6 hrs; 3 episodes of diarrhea; hyperactivity	
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:	Brenna	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 Shepard	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):	15 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State:	NY	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) XXX-XXX-XXXX	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) XX-XXX-XXXX
*Today's Date:	04/27/2009(MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/> (b)(4)
Other:	

Submit

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

Date Received: 04/27/2009

Verified:yes

Reviewed:yes

Date Entered: 03/10/2010

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>CVB Home Page

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: AIV10164

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	916419A	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	S830707	<input checked="" type="checkbox"/> Viral
3 Canine Bordetella Injectable	189	A839036C	<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	LR	22	
2 1 ml	SQ	RR	22	
3 1 ml	SQ	LR	22	
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/17/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Four hours post vaccination w/vomiting, diarrhea and lethargy. Treated with Dexamethasone and Benadryl	
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"/> 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: Dachshund	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 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:	
City:		City:	(b)(6)
State: ND		State: ND	
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6) (XXX-XXX-XXXX)	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) (XXX-XXX-XXXX)
*Today's Date:	07/23/2009(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Other
Other (b)(4)

Submit

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

Date Received: 07/23/2009

Verified:yes

Reviewed:yes

Date Entered: 03/10/2010

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>CVB Home Page

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: AIV10185

Product Code: 1905.24 47K1.20

* 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	S835927A	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5 L4	189	A940421	<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	R hip	25	11/01/2009
2 1 ml	SQ	R hip	22	12/08/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	12/08/2009
Concurrent Drugs or Procedures:	NONE

Event Information

* Event description: Systemic

Explain the event and any treatment in a concise paragraph:

The pet presented on 12/10/09, 2 days after vaccination with diffuse pain/hyperesthesia, shivering and reluctance to walk or get up. His temperature was 104.3. Neurological exam was wnl. He did not show signs of any specific site of pain/discomfort. I treated him as a vaccine reaction, and administered 7.5 mg Diphenhydramine IM and 0.5 mg

Dexamethasone SQ. The pet went home with the owner. On 12/11/09, he presented again. He never improved after the initial injections--he would walk but walked as if drunk. Examination revealed a hunched back, stilted gait, shivering and hyperesthesia. He reacted painfully over the thoracic spine, rib cage and extreme cranial abdomen. CP's are normal all 4 legs. Xrays wnl. Labwork pending. Owner declined referral to int med specialist, so sent home with prednisone 2.5 mg daily, doxycycline 12.5 mg bid, and tramadol 12.5 mg bid.

<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)	2 days
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 in process

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"/> 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.): Had distemper/parvo at breeders, given same Pfizer DA2L4PP on 11/10/2009 with no adverse problem. Indoor except for potty, housed with 2 other dogs.		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	(b)(6)	Address	(b)(6)
City:		City	
State: OH		State: OH	
Zip		Zip	(b)(6)
*Phone	(b)(6)	Phone	(b)(6) X-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) XXX-XXX-XXXX
*Today's Date:	12/11/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> (b)(6)
Other:	

Submit

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

Date Received: 12/11/2009

Verified:yes

Reviewed:yes

Date Entered: 03/17/2010

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>CVB Home Page

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: AIV10211

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 Rabdumun	189		<input checked="" type="checkbox"/> Viral
2 Continuum DAP	286		<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)	10/05/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: 20 minutes after vac injections presented, had vomited, hives & generalized pruritis - pruritis most intense muzzle sign resolved with steroid 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)	15 - 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:	Mishka	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:	Boxer 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):	18 wks		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State:	OH	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) XXX-XXX-XXXX	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:	(b)(6) XXX-XXX-XXXX
*Today's Date:	10/06/2009(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> (b)(4)
Other:	

Submit

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

Date Received: 01/11/2010

Verified:yes

Reviewed:yes

Date Entered: 04/26/2010

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>CVB Home Page

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: AIV10265

Product Code: 1905.24 13D1.20

* 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	189	S843308C	<input checked="" type="checkbox"/> Viral
2 Galaxy DA2PPvL	165A	212398A	<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	R hind	22	01/28/2010
2 1 ml	SQ	Shoulder	22	01/28/2010
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/28/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Developed swollen face/muzzle several hours after vaccine administration. Treated with IV Dex, IM Benadryl, followed by oral benadryl and prednisone.	

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:	Mimi	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"/> Yes		
Age (i.e., 2 yrs or 2 mos):	18 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Same vaccines and manufacturer given at last year's annual with no adverse reaction.			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:		City:	
State:	MA	State:	
Zip:		Zip:	
*Phone:	(b)(6) (XXX-XXX-XXXX)	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:	(b)(6) (XXX-XXX-XXXX)
*Today's Date:	01/29/2010(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/>	(b)(4)
Other:	<input type="checkbox"/>	

Submit

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

Date Received: 01/29/2010

Verified:yes

Reviewed:yes

Date Entered: 06/28/2010

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>CVB Home Page

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: AIV10292

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	S834805C	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

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

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/09/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: lump at injection site, alopecia, blood glucose was high/diabetic. lump burst & the glucose went back down to normal. anorexic - death lump between shoulder blades, pus filled abscess. vetionics.com	

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)	next day
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: tag #014	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: Jack Russel Mix	Number vaccinated: 2	
Sex: <input checked="" type="checkbox"/> Female	Number dead: 1	
Neutered: <input checked="" type="checkbox"/> Not Listed		
Age (i.e., 2 yrs or 2 mos): 12 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): 40 lbs		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:		City:	
State: MA		State: MA	
Zip:	(b)(6)	Zip:	(b)(6)
*Phone: (b)(6) XXX-XXX-XXXX		Phone: (b)(6) XX-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) XXX-XXX-XXXX
*Today's Date:	02/23/2010(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/>	(b)(4)
Other:		

Submit

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

Date Received: 02/23/2010

Verified:yes

Reviewed:yes

Date Entered: 08/18/2010

CVB Reporter: Taylor

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>CVB Home Page

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: AIV10296

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 Rabdumun	189	S843308C	<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	22	02/26/2010
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/26/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Developed facial swelling approximately 1 hour after receiving the vaccine. Administered diphenhydramine IM and Dexamethasone IM. Dog recovered.	

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:	Buster Malone	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):	7 yrs 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		City	
State:	MA	State:	MA
Zip	(b)(6)	Zip	(b)(6)
*Phone	(b)(6) XXX-XXX-XXXX	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:	(b)(6) XX-XXX-XXXX
*Today's Date:	03/01/2010(MM/DD/YYYY)

Relationship to animal:	<input type="checkbox"/> (9)(d)
Other:	

Submit

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

Date Received: 03/01/2010

Verified:yes

Reviewed:yes

Date Entered: 08/18/2010

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>CVB Home Page

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: AIV10304

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	S835928B	<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	22	11/01/2010
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/02/2010
Concurrent Drugs or Procedures:	Benadryl 0.2mls sq pre-vaccine

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: 0.2mls Benadryl given sq prior to vaccination due to previous vaccine reactions. Rabies vaccine given sq. Approximately 3 hours later patient had numerous episodes of vomiting. Administered 0.15mls of Dexamethasone sq and 100mls LRS sq. Monitor rest of 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)	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:		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):	8 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			
Previous vaccination reaction (rabies and distemper given at same time)			

Personal Information

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

*Today's Date: 03/05/2010 (MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> (b)(7)(C)
Other:	(b)(7)(C)

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

Date Received: 03/05/2010

Verified: yes

Reviewed: yes

Date Entered: 08/27/2010

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. <http://www.aphis.usda.gov/vs/cvb/ic/adverseeventreport.htm> CVB Home Page

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: AIV10311

Product Code: 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 Defensor	189	S835928B	<input checked="" type="checkbox"/> Viral
2 Bronchicine CAe	189	A945496	<input checked="" type="checkbox"/> Bacterial
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)	03/06/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
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Explain the event and any treatment in a concise paragraph:
 Premedicated with Benedry IM 0.35cc prior to exam at 1130am. Gave RV and BORD inj. Owner called back around 230pm stating Pucks upper eyelid was swelling. Owner brought Puck back in gave another inj. of Dex 0.4cc IM. Informed owner if any further signs to bring to the RRAEC due to clinic closing. Was brought to the RRAEC they

administered 1cc Dex IM and disp. Pred 5mg SID if needed tomorrow	
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 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"/> Yes			
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.):			

Personal Information

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

*Submitter's Phone Number:	
*Today's Date:	03/08/2010(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Other
Other	(b) (6)

Submit:

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

Date Received: 03/08/2010

Verified:yes

Reviewed:yes

Date Entered: 08/27/2010

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>CVB Home Page

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: AIV10314

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	S844091D	<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	lateral thigh	22	
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/23/2010
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: Acute onset vomiting and weakness/shock within 1/2 hour of administration. Treated with IV crystalloid support, benedyl, dexamethasone, and epinephrine. Vomiting subsided and circulation improved with 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)	20-30 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:	Lucy Echeverria	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):	16 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Adopted at six months of age. No chronic health concerns.			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:		City:	
State:	CA	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) XXX-XXX-XXXX	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:	(b)(6) XXX-XXX-XXXX
*Today's Date:	03/09/2010(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/>	(b)(4)
Other:		

Submit:

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

Date Received: 03/09/2010

Verified:yes

Reviewed:yes

Date Entered: 08/27/2010

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>CVB Home Page

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: AIV10322

Product Code: 1905.24 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	S839987D	<input checked="" type="checkbox"/> Viral
2 Recombitek KC2	124	104-604A	<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	RH	25	03/15/2010
2 0.5 ml	Intranasal	in nose	n/a	03/15/2010
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/15/2010
Concurrent Drugs or Procedures:	annual exam/HW test

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Owner noticed his muzzle swelling and hives developing on his muzzle and back approximately 4-6 hours post-vaccine. Treated with IM injections of diphenhydramine and dexamethasone SP. Owner to continue diphenhydramine orally at 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)	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:	Lenny	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:	Chihuahua	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):	1.5 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): No previous vaccines reactions.		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	(b)(6)	Address	(b)(6)
City:		City	
State:	MD	State:	MD
Zip:	(b)(6)	Zip	(b)(6)
*Phone:	(b)(6) X-XXX-XXXX	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:	03/15/2010(MM/DD/YYYY)		
Relationship to animal:	<input checked="" type="checkbox"/>	(9)(9)	
Other:			

Submit

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

Date Received: 03/15/2010

Verified:yes

Reviewed:yes

Date Entered: 08/31/2010

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>CVB Home Page

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: AIV10334

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	S838777C	<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 lateral humerus	22	
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/09/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph:	
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"/> 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: Beagle		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.): Prior vaccine reaction when he received DA2PP vaccine and Rabies at the same time, not reported		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State: CO		State:	
Zip:		Zip:	
*Phone: (b)(6) XXX-XXX-XXXX		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:	(b)(6) XXX-XXX-XXXX
*Today's Date:	03/25/2010 (MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Other
Other: [REDACTED]

Submit

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

Date Received: 03/25/2010

Verified:yes

Reviewed:yes

Date Entered: 09/08/2010

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>CVB Home Page

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: AIV10335

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	S838777C	<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	
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/22/2010
Concurrent Drugs or Procedures:	Applied Silver Sulfadiazine cream to feet prior to vaccinating

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Dog was given vaccine in clinic. Owner took dog to park and approximately 20-30 minutes after vaccine was given, she collapsed. When she presented at clinic, she had no femoral pulses, heart was hard to hear, and she had harsh,	

raspy lung sounds. Administered Diphenhydramine IM and Dexamethasone IV. After 10 minutes, gum color improved and after 30 minutes, she was able to stand.	
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: Shar Pei		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		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State:	CO	State:	
Zip:		Zip:	
*Phone:	(b)(6) XXX-XXX-XXXX	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:	970-221-9995(XXX-XXX-XXXX)
*Today's Date:	03/25/2010(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	(b)(4)

Submit

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

Date Received: 03/25/2010

Verified:yes

Reviewed:yes

Date Entered: 09/08/2010

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>CVB Home Page

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: AIV10337

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	S839988C	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A948329A	<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	R lateral thigh	23	03/25/2010
2 1 ml	SQ	Intrascapular	23	03/25/2010
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/25/2010
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 edema and hives few hours after vaccinations	
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)	few 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: MacKenzie	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 Russel 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): 4 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Has been vaccinated against rabies 2 previous times and vaccinated against DHPP five previous times. Housed indoors. Healthy.		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State: MT		State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) XXX-XXX-XXXX	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) XXX-XXX-XXXX
*Today's Date:	03/27/2010(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> (b)(4)
Other:	

Submit

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

Date Received: 03/27/2010

Verified:yes

Reviewed:yes

Date Entered: 09/08/2010

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>CVB Home Page

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: AIV10376

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	S839988A	<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	04/12/2010
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/12/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Autoimmune
Explain the event and any treatment in a concise paragraph: IMThrombocytopenia	
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)	next day
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	don't know yet

Animal Information

Case Identification:	Angel	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"/> No		
Age (i.e., 2 yrs or 2 mos):	9 yrs		
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:	WI	State:	WI
Zip:	(b)(6)	Zip:	(b)(6)
*Phone:	(b)(6) (XX-XXX-XXXX)	Phone:	(b)(6) (X-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) (XX-XXX-XXXX)
*Today's Date:	04/26/2010(MM/DD/YYYY)
Relationship to animal:	

	<input checked="" type="checkbox"/>	(b)(4)
Other:		

Submit

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

Date Received: 04/26/2010

Verified:yes

Reviewed:yes

Date Entered: 09/23/2010

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>CVB Home Page

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: AIV10400

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	S846249A	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF shoulder	25	05/04/2010
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/04/2010
Concurrent Drugs or Procedures:	Anal sac expression, ear cytology swab, blood draw

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
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Explain the event and any treatment in a concise paragraph:
 After arriving home from appointment, owner noticed muzzle and lips of canine were swollen. Owner called NCAH and was advised to come straight down. Possible vx reaction. Upon arrival SQ edema and swelling periorcular and on

muzzle. Treatment included Dexamethasone SP, Diphenhydramine and SQ 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)	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:	2929	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:	Cocker Spaniel	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):	13 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Obtained 1997 breeder in Ohio, chronic otitis, current dental disease, fed dry commercial diet, 2 cats in household, indoor/outdoor & neighborhood walks.			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	(b)(6)
City:		City:	
State:	AZ	State:	AZ
Zip:		Zip:	(b)(6)
*Phone:	(b)(6) (X-XXXX)	Phone:	(b)(6) (X-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) (b)(7)(C)	XXX-XXX-XXXX
*Today's Date:	05/11/2010(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/>	(b)(6) (b)(7)(C)
Other:		

Submit

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

Date Received: 05/15/2010

Verified:yes

Reviewed:yes

Date Entered: 09/23/2010

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>CVB Home Page

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: AIV10404

Product Code: 1905.24 47K1.20 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 1	189	5947581B	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5 L4	189	A947281	<input checked="" type="checkbox"/> Combination
3 Vanguard CV	189	A947119B	<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	IM	RH quarter		05/13/2010
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/13/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: Dog had vomiting first, then followed by confusion, unable to follow commands, with open staring eyes, even at sleep . . lethargic, muscle weakness and lack of hind quarter coordination. Did not eat or drink for 2 days and generalized pain. Remadly 100 mg for pain.	

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 and continuing	
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:	2010-US-18936	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:	Wheaton 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):	7 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): has never had a reaction to these vaccinations before.			

Personal Information

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

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: AIV10407

Product Code: 1905.24 14M1.20 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 Rabdomun 1	189	S947582A	<input checked="" type="checkbox"/> Viral
2 Intra-Trac II	165A	53668	<input checked="" type="checkbox"/> Bacterial
3 Duramune Cv-K	112	145272B	<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	R hip	25	05/11/2010
2 1 ml	IN	Nares	n/a	05/11/2010
3 1 ml	SQ	R shoulder	25	05/11/2010
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/11/2010
Concurrent Drugs or Procedures:	na

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: vomiting/diarrhea	
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 with treatment
Other:	

Animal Information

Case Identification:	Hope	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:	Cocker Spaniel	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.):			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State:	OH	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) (XXX-XXX-XXXX)	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	(b)(6) (XXX-XXX-XXXX)
*Today's Date:	05/20/2010(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/>	(b)(9)
Other:	

Submit

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

Date Received: 05/20/2010

Verified:yes

Reviewed:yes

Date Entered: 09/29/2010

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>CVB Home Page

Adverse Event Report

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 United States Department of Agriculture
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 Ames, IA 50010
 Phone: (515) 232-5785
 FAX: (515) 232-7120

Record Number: AIV10417

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	916531A	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	S947580	<input checked="" type="checkbox"/> Viral
3 Intra-Trac 3	165A	54211B	<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	LR leg	22	05/18/2010
2 1 ml	SQ	RR leg	22	05/18/2010
3	IN	IN		05/18/2010
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/18/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vaccinated for Dapp, Bord, RV, O went into lobby with dog and he collapsed, brought back to treatment room gums very pale, placed IV catheter bolused 250mls LRS, administered diphenhydramine 15.5mg IM and Solu-delta cortef 77mg IV	

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:		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"/> Male	Number dead:0
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	3 yrs 9 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): not known		

Personal Information

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

*Today's Date:	05/26/2010(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: 05/26/2010

Verified:yes

Reviewed:yes

Date Entered: 09/29/2010

CVB Reporter:

Acknowledgement:

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 Ames, IA 50010
 Phone: (515) 232-5785
 FAX: (515) 232-7120

Record Number: AIV10418

Product Code: 1905.24 12X1.20 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 3	189	S947580	<input checked="" type="checkbox"/> Viral
2 Intra-Trac 3	165A	54211B	<input checked="" type="checkbox"/> Combination
3 Durmune Max 5	112	916531A	<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	22	05/18/2010
2	IN	IN		05/18/2010
3 1 ml	SQ	LR leg	22	05/18/2010
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/18/2010
Concurrent Drugs or Procedures:	n/a

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vaccinated around 9:30 am, O was out in the Lobby waiting to pay and dog vomited 2 times, very lethargic. Upon physical exam dog was extremely lethargic and weak. Temp- 101.2, HR 100, RR 44, femoral pulses were weak and thready, mucous membranes pale unable to assess CRT, Placed IV catheter bolused 280mls LRS and administered	

7.5mg Diphenhydramine IM and 35mg Solu-delta-cortef IV.

<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"/> 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 :Maltese		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 3 mos			
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

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

*Submitter's Phone Number:	
*Today's Date:	05/26/2010(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: 05/26/2010

Verified:yes

Reviewed:yes

Date Entered: 09/29/2010

CVB Reporter:

Acknowledgement:

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

Record Number: AIV10424

Product Code: 13D1.29 2668.05 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	916530A	<input checked="" type="checkbox"/> Viral
2 LCI-GP	112	350265A	<input checked="" type="checkbox"/> Bacterial
3 Rabdomun 1	189	S845209	<input checked="" type="checkbox"/> Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF leg	25	04/23/2010
2 1 ml	SQ	RF leg	25	04/23/2010
3 1 ml	SQ	RR leg	25	04/23/2010
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/23/2010
Concurrent Drugs or Procedures:	exam, cleaned ears

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: lethargy and very pale gums; the patient defecated in the clinic and became lethargic with very pale gums. Then benadryl (IM) and dexamethasone IV given at clinic. Monitored at the clinic for 1 hour before sent home. gums became pink again after 2-3 mins.	

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:	suspect leptovax

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"/> No		
Age (i.e., 2 yrs or 2 mos): 15 wks		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

Personal Information

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

*Today's Date: 06/09/2010(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/> Other
Othe	(b)(4)

Submit

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

Date Received: 06/10/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

CVB Reporter:

Acknowledgement:

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

Record Number: AIV10427

Product Code: 1905.24 16D1.20

* 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 Rabdomun 1	189	S838776A	<input checked="" type="checkbox"/> Viral
2 Eclipse 3	165A	206209B	<input checked="" type="checkbox"/> Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	03/25/2010
2 1 ml	SQ	RF leg	25	03/25/2010
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/25/2010
Concurrent Drugs or Procedures:	none,exam

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: vomited and red, inflammed skin with welts; the patient experienced vomiting and red, inflammed skin with welts on its head about 1.5 hours after vax. given diphenhydramine (IM) and dexamethasone (IV) at clinic and then sent 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)	1.5 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"/> Feline (Cat)	Number in group: 1
(Other Species):	Number affected: 1
Breed: DMH	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 6 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): no previous vaccine reactions	

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State: FL		State:	
Zip:		Zip:	
*Phone:	(b)(6) XX-XXX-XXXX	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:	(b)(6) XX-XXX-XXXX
*Today's Date:	06/09/2010(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other	(b)(6)

Submit

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

Date Received: 06/10/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

CVB Reporter:

Acknowledgement: yes

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Adverse Event Report

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 United States Department of Agriculture
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 510 South 17th Street, Suite 104
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 Phone: (515) 232-5785
 FAX: (515) 232-7120

Record Number: AIV10428

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	S838776A	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	03/22/2010
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/22/2010
Concurrent Drugs or Procedures:	none, exam, heartworm, fecal flotation

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: swelling & redness/inflammation; the patient experienced facial swelling and red bumps after vaccination. owner was advised to give benadryl. patient recovered at 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)	later that evening
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:	DMH	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 7 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): no previous vaccine reactions		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State:	FL	State:	
Zip:	(b)(6)	Zip:	
*Phone:	(b)(6) XXX-XXX-XXXX	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	(b)(6) XXX-XXX-XXXX
*Today's Date:	06/09/2010(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other	(b)(4)

Submit

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

Date Received: 06/10/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

CVB Reporter:

Acknowledgement: yes

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

Record Number: AIV10432

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	S846249D	<input checked="" type="checkbox"/> Viral
2 Fel-O-Guard Plus 3	112	117182B	<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	RR leg	23	06/02/2010
2 1 ml	SQ	R shoulder	23	06/02/2010
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/02/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vomited several time in car on the 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)	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 without treatment
Other:	

Animal Information

Case Identification:	8451	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):	4 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	(b)(6)	Address:	
City:		City:	
State:	MN	State:	
Zip:		Zip:	
*Phone:	(b)(6) (XXX)	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:	
*Submitter's Phone Number:	(b)(6) (XXX-XXX-XXXX)
*Today's Date:	06/10/2010(MM/DD/YYYY)
Relationship to animal:	

<input type="checkbox"/> Other
Other (b) (6)

Submit

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

Date Received: 06/10/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

CVB Reporter:

Acknowledgement:

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Adverse Event Report

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

Record Number: AIV10436

Product Code: 16D8.21 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 PureVax Feline 3	298	66152	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	S947985C	<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	25	06/11/2010
2 1 ml	SQ	RH leg	25	11/01/2010
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/11/2010
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: The client left the hospital the cat vomited and had diahrrhea. The owner turned back and the hospital gave treatment for 5 hours. The client returned to the hospital for more 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)	15-20-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:	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 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): 1 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:		City:	
State: NY		State: NY	
Zip:		Zip:	(b)(6)
*Phone: (b)(6) (-XXXX)		Phone: (b)(6) (X-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) (XXX-XXX-XXXX)
*Today's Date:	06/14/2010(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other	(b)

Submit

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

Date Received: 06/14/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

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>CVB Home Page

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: AIV10441

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	S846248B	<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 limb	22	06/11/2010
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/11/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vomiting numerous times, Tachycardia	
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)	Roughly 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: 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): 10 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		City:	
State: OH		State:	
Zip		Zip:	
*Phone (XXX-XXX-XXXX)	(b)(6)	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	(b)(6) (XXX-XXX-XXXX)
*Today's Date:	06/18/2010(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Other
Other (b)(4)

Submit

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

Date Received: 06/18/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

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>CVB Home Page

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: AIV10446

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	S838996B	<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	L side		
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Non-veterinarian
*Date of Product Use:(MM/DD/YYYY)	06/19/2010
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 quickly began slobbering, dragging legs and becoming unable to move on the side shot as administered on; glassy eyes; spaced out etc. Received epinephrine & Dexamethasone and mostly recovered; still slight gait difference 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)	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:	After 72 hours was still slight gait abnormality on side of injection

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: Greyhound		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		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): adopted via greyhound rescue; up to date on vaccinations; no medical conditions or issues; house pet		

Personal Information

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

*Today's Date:		06/22/2010(MM/DD/YYYY)	
Relationship to animal:	<input checked="" type="checkbox"/>	(b)(4)	
Other:		(b)(4)	

Submit

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

Date Received: 06/22/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

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>CVB Home Page

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: AIV10447

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	S839988C	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A948802	<input checked="" type="checkbox"/> Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 0.25 ml	IM	Rhip	22	
2 0.4 ml	SQ	Shoulder blades	22	
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/12/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: 1 hour after vaccines were given, vomited multiple times, gums slightly pale upon arrival, gave dex & DIPH & within 10-15 mins doing well MM pink.	

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:	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: Maltipoo	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): 3.5 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:		City:	
State: MN		State:	
Zip:		Zip:	
*Phone: (b)(6) XX-XXX-XXXX		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:	(b)(6) XX-XXX-XXXX
*Today's Date:	06/24/2010(MM/DD/YYYY)

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

[Submit](#)

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

Date Received: 06/24/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

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>CVB Home Page

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: AIV10448

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	S839988C	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A948802	<input checked="" type="checkbox"/> Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Between shoulder blades	24	
2 1 ml	SQ	R hip	24	
3 1 ml	SQ	Between shoulder blades	24	
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/10/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: about 10 mins after giving rabies & DHPP vac started Q & stollod uncontrollably, stumbly & blue mm. very little response. gave des, diph & epi - after giving meds - within 30 mins sitting up MM pink & less ataxic.	

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:		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: Chihuahua		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.): vaccine reaction		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	(b)(6)	Address:	
City:		City:	
State: MN		State:	
Zip:		Zip:	
*Phone:	(b)(6) XXX)	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:	(b)(6) XX-XXX-XXXX)
*Today's Date:	06/24/2010(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: 06/24/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

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>CVB Home Page

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: AIV10449

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	S839988C	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A948802	<input checked="" type="checkbox"/> Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Inbetween shoulder blades	22	
2 1 ml	IV	Vein	24	
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/07/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: After vaccine were given and got home, passed a large amount of stool & then vomited. Gave dexamethasone & DIPH - within a few minutes mucous membranes - pink & temp 100.3.	

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 - 25 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: 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): 4 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:		City:	
State: MN		State:	
Zip:		Zip:	
*Phone:	(b)(6) XXX	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:	(b)(6) XX-XXX-XXXX
*Today's Date:	06/24/2010(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: 06/24/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

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>CVB Home Page

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: AIV10461

Product Code: 1905.24 47K1.20 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 Defensor 3	189	S950683B	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5 L4	189	A946410	<input checked="" type="checkbox"/> Combination
3 Bronchicine CAe	189	A051715B	<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	R femur	25	07/05/2010
2 1 ml	SQ	R humerus	25	07/05/2010
3 1 ml	SQ	L humerus	25	07/05/2010
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/05/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Swollen muzzle, lethargy and vomiting. Treated at emergency clinic with 6 mg prednisolone SQ and 6 mg diphenhydramine IM. Prednisone was sent home to be given orally.	

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)	3-4 hs
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: Miniature 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):	15 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): No previous vaccine reactions. Received rabies, DHLPP and intranasal Bordetella vaccines in 7/09 without reaction.			

Personal Information

Veterinarian		Owner	
*Name:	(b)(4)	Name:	
Address:	(b)(4)	Address:	
City:		City:	
State: IA		State:	
Zip:	(b)(4)	Zip:	
*Phone: (b)(4) XXX-XXX-XXXX		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)(4)
*Submitter's Last Name:	(b)(4)
*Submitter's Phone Number:	(b)(4) XXX-XXX-XXXX
*Today's Date:	07/06/2010(MM/DD/YYYY)

Relationship to animal:	<input type="checkbox"/>	(b)(4)
Other:		

Submit

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

Date Received: 07/06/2010

Verified:yes

Reviewed:yes

Date Entered: 09/30/2010

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>CVB Home Page