

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: AIV10249

Product Code: 1905.23 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 Rabvac 3 TF	112	873193A	<input checked="" type="checkbox"/> Viral
2 Duramune Adult 3	112	1867115A	<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 hip	22	12/18/2009
2 1 ml	SQ	R shoulder	22	12/18/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	12/18/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Acute vomiting followed by collapse. Administered steroids, benadryl, iv fluids.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

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

Onset (How long after product use did the event begin?) (Include Units:mins, hrs, days, wks, mos, yrs)	3 to 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:	319 A	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):	1 yrs 9 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Administered in veterinary hospital, lives in a private home, no previous history of allergic reaction.			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Greensboro Veterinary Hospital 3741 High Point Road	Address:	
City:	Greensboro	City:	
State:	NC	State:	NC
Zip:	27407	Zip:	
*Phone:	336-299-5431(XXX-XXX-XXXX)	Phone:	(b)(6)
FAX:	336-299-5441		
E-mail:	gsoveterinaryhosp@triad.rr.com	E-mail:	gsoveterinaryhosp@triad.rr.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:	336-299-5431(XXX-XXX-XXXX)
*Today's Date:	01/19/2010(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 01/19/2010

Verified:yes

Reviewed:yes

Date Entered: 06/09/2010

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

Record Number: AIV10232

Product Code: 2668.05 2126.00 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 LeptoVax 4	112	045147A	<input checked="" type="checkbox"/> Bacterial
2 LymeVax	112	229198A	<input checked="" type="checkbox"/> Bacterial
3 Intra-Trac 3	165A	54177A	<input checked="" type="checkbox"/> Combination
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	25	09/02/2009
2 1 ml	SQ	Central shoulder	25	09/02/2009
3 1 ml	IN		NA	09/02/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/02/2009
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: presented with facial swelling - submandibular area, lethargic. given diphenhydramine 50 mg PO & dexamethasone SP 9.3 mg SQ	

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: German Shepard	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): approx 6 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): received leptos in past - no rxn, first time receiving lyme & Bord, no other animals in house hold, feeding natural choice		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Burleigh Road Animal Hospital 13725 West Burleigh Road		Address: (b)(6)	
City: Brookfield		City: (b)(6)	
State: WI		State: WI	
Zip: 53005		Zip: (b)(6)	
*Phone: 262-781-4400 (XXX-XXX-XXXX)		Phone: (b)(6) (XXX-XXX-XXXX)	
FAX: 262-781-4504			
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:	262-781-4400 (XXX-XXX-XXXX)
*Today's Date:	01/07/2010 (MM/DD/YYYY)

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

Submit

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

Date Received: 01/07/2010

Verified:yes

Reviewed:yes

Date Entered: 05/04/2010

CVB Reporter:

Acknowledgement: yes

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

Record Number: AIV10210

Product Code: 2668.00

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard L4	189	A940906A	<input checked="" type="checkbox"/> Bacterial
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)	09/12/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: pet returned with facial swelling approx. 3.5 hrs after leptu injection. pet was treated with an injection of diphenhydramine. 0.1 cc IM and an injection of dexamethasone 0.5 cc SQ - observed for remainder of day. informed client to give benadryl 10 mg orally every 8 hrs for 2 days. if swelling remains or worsens proceed to EC.	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3.5 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: Chihuahua	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Not Listed		
Age (i.e., 2 yrs or 2 mos): 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:	VCA Woodlands Animal Hospital 428 Rayford Road	Address:	
City:	Spring	City:	
State:	TX	State:	
Zip:	77386	Zip:	
*Phone:	281-367-7553(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:	281-367-7553(XXX-XXX-XXXX)

*Today's Date:	09/12/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 01/11/2010

Verified:yes

Reviewed:yes

Date Entered: 04/19/2010

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

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

Record Number: AIV10208

Product Code: 2668.00

*** Required Fields**

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard L4	189	A833410A	<input checked="" type="checkbox"/> Bacterial
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)	05/23/2009
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: Patient developed erythematous eruptions around muzzle & upper eyelids about 45 m - 1 hr post vax. Pt was taken back into hospital and diphenhydramine was subsequently administered.	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	45 mins to 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) (Other Species):	Number in group:1
Breed: Chihuahua Smoothcoat	Number affected:1
Sex: <input checked="" type="checkbox"/> Female	Number vaccinated:1
Neutered: <input checked="" type="checkbox"/> Yes	Number dead:0
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: VCA Woodlands 428 Rayford Road		Address: (b)(6)	
City: Spring		City: (b)(6)	
State: TX		State: TX	
Zip: 77382		Zip: (b)(6)	
*Phone: 281-367-7553(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:	281-367-7553(XXX-XXX-XXXX)
*Today's Date:	05/23/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 01/11/2010

Verified:yes

Reviewed:yes

Date Entered: 04/19/2010

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: AIV10206

Product Code: 2668.00

*** Required Fields**

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard L4	189	A839157A	<input checked="" type="checkbox"/> Bacterial
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R lateral shoulder	22	10/07/2009
2				
3				
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"/> Autoimmune
Explain the event and any treatment in a concise paragraph: Ted (5 yr old German Shorthair intact male) received a Vanguard L4 vaccine on 10/7/09. The owners noticed a decreased energy level and decreased appetite shortly after Vanguard Lepto 4 vaccine was given. Ted began vomiting on 10/17 and was brought into our clinic. Bloodwork was done and it was determined that he was losing

protein in the urine. He was referred to Mich State on 10/20 (see MSV write up). Ted was euthanized on 10/29 and a necropsy was done report included final diagnosis - renal amyloidosis. Owner felt that Ted started having problems immediately after vaccine was given. He first presented at clinic 10 days after vaccine given. At that time he had an elevated WBC & kidney problems (losing protein in urine). He was euthanized 3 wks after vaccine given.

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?): approx. 2 days
(Include Units:mins, hrs, days, wks, mos, yrs)

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

*Outcome (select one): Did not recover

Other: euthanized

Animal Information

Case Identification:	Ted	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:	German Shorthair Pointer	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 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:	Midland Animal Clinic 1312 Vance Road	Address:	(b)(6)
City:	Midland	City:	(b)(6)
State:	MI	State:	MI
Zip:	48642	Zip:	(b)(6)
*Phone:	989-631-0220(XXX-XXX-XXXX)	Phone:	(b)(6) XX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

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

*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number:	989-631-0220(XXX-XXX-XXXX)
*Today's Date:	10/30/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 01/14/2010

Verified:yes

Reviewed:yes

Date Entered: 04/19/2010

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

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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: AIV10205

Product Code: 2668.05

*** 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 LCI-GP	112		<input checked="" type="checkbox"/> Bacterial
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)	11/25/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: pet became itchy, scratching, started vomiting. severe bloody diarrhea, swelling of face & head. administered benadryl, famotidine, cerenia and reglan.	

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 to 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"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: chihuahua mix	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Not Listed	
Age (i.e., 2 yrs or 2 mos): 6 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):	

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Santa Cruz Vet Hospital 2585 Soquel Drive		Address:	
City: Santa Cruz		City:	
State: CA		State:	
Zip: 95062		Zip:	
*Phone: 831-475-5400(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:	831-475-5400(XXX-XXX-XXXX)
*Today's Date:	11/25/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 01/11/2010

Verified:yes

Reviewed:yes

Date Entered: 04/19/2010

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: AIV10200

Product Code: 13D1.29 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 Duramune Max 5	112	916459A	<input checked="" type="checkbox"/> Viral
2 CvK/LCI-GP	112	094239B	<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	unk	unk	12/28/2009
2 1 ml	SQ	unk	unk	12/28/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Non-veterinarian
*Date of Product Use:(MM/DD/YYYY)	12/28/2009
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:
 About 10 minutes after administration at home, the dog collapsed. Presented to veterinarian a few minutes later. Dog was unresponsive, poor pulses, poor color, irregular breathing and nystagmus. Peripheral blood pressure not detectable. blood glucose 114. pcv 24, tp 4.0. Administered shock dose of LRS, epinephrine, dexSP, and atropine.

Patient recovered over a period of several 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?): 10 mins
(Include Units:mins, hrs, days, wks, mos, yrs)

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

*Outcome (select one): Recovered with treatment

Other:

Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Lab 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): 16 wks	
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: Primary Care Dog & Cat Hospital 1127 Mesa View Drive		Address: (b)(6)	
City: Arroyo Grande		City: (b)(6)	
State: CA		State: CA	
Zip: 93420		Zip: (b)(6)	
*Phone: 805-489-4307(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)
	805-489-4307(XXX-XXX-XXXX)

*Submitter's Phone Number:	
*Today's Date:	01/04/2010(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

[Submit](#)

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

Date Received: 01/04/2010

Verified:yes

Reviewed:yes

Date Entered: 04/19/2010

CVB Reporter:

Acknowledgement:

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

Record Number: AIV10199

Product Code: 1905.23 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 Rabvac 3	112	873178A	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916481A	<input checked="" type="checkbox"/> Viral
3 Intra-Trac 3	112	112452C	<input checked="" type="checkbox"/> Combination
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	25	11/06/2009
2 1 ml	SQ	L shoulder	25	11/06/2009
3 1 ml	IN	Nose	N/A	11/06/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/06/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: 1/2 inch transdermal mass on right shoulder.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	6 wks
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> 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: Yorkshire Terrier Mix	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 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: Tates Creek Animal Hospital 4101 Tates Creek Centre Drive		Address:	
City: Lexington		City:	
State: KY		State:	
Zip: 40517		Zip:	
*Phone: 859-273-1933(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:	859-273-1933(XXX-XXX-XXXX)
*Today's Date:	01/04/2010(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: 01/04/2010

Verified:yes

Reviewed:yes

Date Entered: 04/19/2010

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: AIV10196

Product Code: 1905.20 4637.29

* 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 Imrab 3	298	12532C	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5/4L	112	53448A258A	<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	shoulder	22	11/01/2009
2 1 ml	SQ	shoulder	22	12/22/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	12/22/2009
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:
 "Obi" is an intact male black and tan Silkie Terrier who was born on 8-21-08. He presented for vaccines and was given a DHLPP/P and an IMRAB 3 rabies vaccine (no other treatments or medications were given). Within 10 minutes he started vomiting and developed bloody diarrhea. He was given diphenhydramine SC but continued to deteriorate

to shock and collapse. 1.0ml dexamethazone (2mg/ml) was given SC, followed by 0.5ml dexamethazone IV once an IV catheter was placed. 2.5% dextrose in saline was also started and "Obi" slowly recovered from the reaction.

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: Silkie 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): 15 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
 Obtained at 5 mos old (2/18/08). Gave Fort Dodge rabies vaccine. Dog vomited the next day and for 7 days following. At 6 mos old (3/13/08), presented for DHLPP vaccine, also recieved Interceptor on that visit. Dog went to emergency clinic the next day after they gave the dog some wheat bread and the eyes began to swell and he started vomiting. On 12/22/2009 presented for allergies (scratching ears, puffy eyes). Updated vaccines with DHLPP and IMRAB 3 rabies. Reaction occured 10 minutes later.

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	Gentle Care Animal Hospital PC 1365 Thomas Jefferson Road	Address	(b)(6)
City:	Forest	City	(b)(6)
State:	VA	State:	VA
Zip:	24551	Zip	(b)(6)
*Phone:	434-534-9894(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX
FAX:	434-534-6082		
E-mail:	jgillesp@vt.edu	E-mail:	

This event has been reported to	<input checked="" type="checkbox"/> No
---------------------------------	--

the manufacturer(s):	
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number:	434-534-9894(XXX-XXX-XXXX)
*Today's Date:	12/28/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 12/28/2009

Verified:yes

Reviewed:yes

Date Entered: 04/19/2010

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: AIV10195
 Product Code: 2668.05 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 LeptoVax 4	112	045154A	<input checked="" type="checkbox"/> Bacterial
2 Galaxy DA2PPvL	165A	212369A	<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	LF	22	12/03/2009
2 1 ml	SQ	RF	22	12/03/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Non-veterinarian
*Date of Product Use:(MM/DD/YYYY)	12/03/2009
Concurrent Drugs or Procedures:	o was giving oral ver the counter Benadryl 50 mg once daily.

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: subcutaneous swelling at site of left should dorsolaterally and diffuse subcutaneous swelling ventral to this site into left axillary region, this swelling was soft and warm to the touch and painful. Temperature upon presentation for local	

vaccine site reaction was 101.7 F.

<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)	24 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	Very suspicious of the Leptospirosis vaccine (which he has had in the past on 11/11/09).

Animal Information

Case Identification:	24979	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:	Mix 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):	1.5 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:	North Smithfield Animal Hospital 152 School Street, P.O. Box 129	Address:	(b)(6)
City:	Forestdale	City:	(b)(6)
State:	RI	State:	RI
Zip:	02824	Zip:	(b)(6)
*Phone:	401-762-2400(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX
FAX:	401-765-7679		
E-mail:	jennifer.dauphin@charter.net	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:	401-762-2400(XXX-XXX-XXXX)
*Today's Date:	12/22/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 12/22/2009

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: AIV10193
 Product Code: 13D1.29 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 Duramune Max 5	112	916429A	<input checked="" type="checkbox"/> Viral
2 Duramune Cv-K	112	145267A	<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 Dry product combined with #2 and given together	SQ	R shoulder	22	12/15/2009
2 Used to reconstitute #1--given together	SQ	R shoulder	22	12/15/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	12/15/2009
Concurrent Drugs or Procedures:	examination

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Angioedema and urticaria approx. 12 hours after vaccination. Owner administered oral diphenhydramine 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)	12 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:	Daphne	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:	French bulldog	Number vaccinated:1	
Sex:	<input checked="" type="checkbox"/> Female	Number dead:0	
Neutered:	<input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos):	3 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): On 10/11/09, 10/25/09, and 11/22/09, pup received a Galaxy brand vaccine, with Distemper, Hepatitis (CAV-2), Parvovirus, Leptospirosis, and Coronavirus--from breeder.			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Cape Cod Animal Hospital 1415 Osterville Road	Address:	
City:	W. Barnstable	City:	(b)(6)
State:	MA	State:	MA
Zip:	02668	Zip:	(b)(6)
*Phone:	508-428-6393(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	508-420-3192		
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:	508-428-6393(XXX-XXX-XXXX)

*Today's Date:	12/18/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 12/18/2009

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: AIV10192

Product Code: 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 Duramune Adult 3	112	1867113A	<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	11/24/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/24/2009
Concurrent Drugs or Procedures:	examination

Event Information

* Event description: <input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: Vomiting, urticaria--day following vaccination. Treated with diphenhydramine 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)	24 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

Animal Information

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

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Cape Cod Animal Hospital 1415 Osterville Road		Address:	
City: W. Barnstable		City: (b)(6)	
State: MA		State: MA	
Zip: 02668		Zip: (b)(6)	
*Phone: 508-428-6393(XXX-XXX-XXXX)		Phone: (XXX-XXX-XXXX)	
FAX: 508-420-3192			
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:	508-428-6393(XXX-XXX-XXXX)
*Today's Date:	12/18/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 12/18/2009

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: AIV10190
 Product Code: 1331.20 1905.23

*** Required Fields**

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Adult 3	112	1867112A	<input checked="" type="checkbox"/> Viral
2 Rabvac 3 TF	112	873185A	<input checked="" type="checkbox"/> Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	22	12/12/2009
2 1 ml	SQ	R hind	22	12/12/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	12/12/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: patient vaccinated for DA2PP & rabies on 12/12/09. 12/13/09 - patient very painful on R hip - decreased appetite mild fever. TX 0.25 ml benadryl inj; 0.25 ml metacam inj. Rx - oral metacam. 1.3 ml PO SID x 3 (start 12/14/)	

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

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

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	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.): no previous vaccine problems, VID with vaccines.		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: River Road Veterinary Hospital 176 River Road		Address: (b)(6)	
City: Andover		City: (b)(6)	
State: MA		State: MA	
Zip: 01810		Zip: (b)(6)	
*Phone: 978-687-8400(XXX-XXX-XXXX)		Phone: (b)(6) XXX-XXX-XXXX	
FAX: 978-687-2025			
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:	978-687-8400(XXX-XXX-XXXX)
*Today's Date:	12/16/2006(MM/DD/YYYY)

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

Submit

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

Date Received: 12/22/2009

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: AIV10187

Product Code: 13D1.22 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 Vanguard Plus 5	189	A940429B	<input checked="" type="checkbox"/> Viral
2 Bronchi-Shield III	112	112468C	<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 shoulder	23	12/10/2009
2 1 ml	IN	nostrils	none	12/10/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Non-veterinarian
*Date of Product Use:(MM/DD/YYYY)	12/10/2009
Concurrent Drugs or Procedures:	Plucked ears & cleaned with Gent L Clens ((Schering-Plough) and applied Otobiotic (Butler) to both external ear canals

Event Information

* Event description: Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:

Dog began breathing heavily with increased effort almost immediately after vaccinations administered. Retched unproductively. Dexamethasone and diphenhydramine given IM immediately. Pet seemed weak, pale mucus membranes still 5 minutes later, so IV catheter placed & IV fluid bolus & IV dexamethasone & IV epinephrine given. Dog continued to look weak, within 5 minutes began expelling pink fluid from nose & mouth & arrested. Resuscitation initially successful - intubated & ventilated, IV epi repeated, lasix, atropine, rapid IV fluids, and chest compressions initiated. Heart began beating effectively again and dog breathed spontaneously. Changed to hetastarch, repeated atropine due to slow heart rhythm, but dog arrested again. Subsequent attempts to resuscitate 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?): 30 secs
(Include Units: mins, hrs, days, wks, mos, yrs)

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

*Outcome (select one): Died

Other:

Animal Information

Case Identification:	940	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 schnauzer	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	1
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	11 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): House pet, had been vaccinated annually for bordatella and every 3 years for DA2PP. Previous vaccine reaction to leptospirosis vaccine. (Details not available as vaccine was given by vet in another state.)			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Bath Brunswick Veterinary Associates 257 Bath Road	Address:	(b)(6)
City:	Brunswick	City:	(b)(6)
State:	ME	State:	ME
Zip:	04011	Zip:	(b)(6)
*Phone:	207-729-4164(XXX-XXX-XXXX)	Phone:	(b)(6) (X-XXX-XXXX)
FAX:			

E-mail: |petvet@bbvet.com

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:	207-729-4164(XXX-XXX-XXXX)
*Today's Date:	12/11/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 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: 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:	<input checked="" type="checkbox"/> 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.

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?): 2 days
(Include Units:mins, hrs, days, wks, mos, yrs)

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

*Outcome (select one): 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: Avon Animal & Bird Hospital 37160 Detroit Road		Address: (b)(6)	
City: Avon		City: (b)(6)	
State: OH		State: OH	
Zip: 44011		Zip: (b)(6)	
*Phone: 440-934-6516(XXX-XXX-XXXX)		Phone: (b)(6) XXX-XXX-XXXX	
FAX: 440-934-5087			
E-mail: avonanimalhosp@centurytel.net		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:	440-934-6516(XXX-XXX-XXXX)
*Today's Date:	12/11/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 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: AIV10177

Product Code: 13D1.29 2668.05 1905.24 15K5.20

*** 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	916485A	<input checked="" type="checkbox"/> Viral
2 LCI-GP	112	350263A	<input checked="" type="checkbox"/> Bacterial
3 Imrab 1 TF	298	22020B	<input checked="" type="checkbox"/> Viral
4 CIV H3N8	165A	219107	<input checked="" type="checkbox"/> Viral

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	22	11/23/2009
2				
3 1 ml	SQ	R hip	22	11/23/2009
4 1 ml	SQ	L shoulder	22	11/23/2009

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/23/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: vax done at 5:45 p.m.; owner called pager at 9 p.m. - swollen eyes, hives - instructed to give 25 mg diphenhydramine x 2. This helped, but then swelled up again. Saw at clinic, gave Dex (0.1 mg/kg dose) IV. Later went to EMT clinic - continued hives, swelling. IM injection of diphenhydramine given (50 mg/ml 0.75 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: Weimaraner	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.): had CIV on 10/10/09 (no problems); had duramune max 5 on 10/10/09 (no problems)	

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Ames Pet Hospital, PC 1400 Dickinson Avenue; P.O. Box 1596		Address: (b)(6)	
City: Ames		City: (b)(6)	
State: IA		State: IA	
Zip: 50014		Zip: (b)(6)	
*Phone: 515-292-8885(XXX-XXX-XXXX)		Phone: (b)(6) (XXX-XXX-XXXX)	
FAX: 515-292-3033			
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:	515-292-8885(XXX-XXX-XXXX)

*Today's Date:	12/04/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 12/14/2009

Verified:yes

Reviewed:yes

Date Entered: 03/15/2010

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: AIV10176

Product Code: 4637.20

*** 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 Canine Spectra 7	165A	UV-100-0288	<input checked="" type="checkbox"/> Combination
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		back on neck		12/02/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Non-veterinarian
*Date of Product Use:(MM/DD/YYYY)	12/02/2009
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: I gave the vaccine to my dog. Later on I noticed the skin around his eyes were red. By 4 pm, his eyes were swollen. I have given him 50mg of Benadryl, which has help the discoloration and very little swelling.	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 to 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"/> Other
Other:	still administering benadryl

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"/> Male	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs 8 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): house dog		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: 3925 Apache Trail		Address: (b)(6)	
City: Antioch		City: (b)(6)	
State: TN		State: TN	
Zip: 37013		Zip: (b)(6)	
*Phone: 615-833-7474(XXX-XXX-XXXX)		Phone: (b)(6) -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) XXX-XXX-XXXX)
*Today's Date:	12/02/2009(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Owner
Other: It will be reported to the manufacturer now!

Submit

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

Date Received: 12/02/2009

Verified: yes

Reviewed: yes

Date Entered: 03/15/2010

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. <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: AIV10175
 Product Code: 1905.20 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 Rabvac 1	112	1212178A	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916481A	<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 hip	25	10/15/2009
2 1 ml	SQ	R shoulder	25	10/15/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/15/2009
Concurrent Drugs or Procedures:	None

Event Information

* Event description: Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
 Approximately 2 hours after vaccine the owner noticed facial swelling and whole body pruritis. The owner gave 25 mg of Children's Diphenhydramine at home as directed by DVM. One hour after administration of the Diphenhydramine, the owner brought the patient in for an exam which was normal other than facial swelling. The patient was treated with

6.4 mg Dexamethasone SP IV and instructed to continue Diphenhydramine for 48 hours.

<p align="center">If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.</p>	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	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:	Teddy	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:	Shepherd 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		
<p>History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Foster puppy previously vaccinated with Fort Dodge DURAMUNE Max 5 on 9/22/09 with no reaction. Housed indoors at foster home with 2 littermates. Littermates did not react to same series of vaccination.</p>			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	Zionsville Animal Hospital 1305 Parkway Drive	Address	(b)(6)
City:	Zionsville	City	(b)(6)
State:	IN	State:	IN
Zip:	46077	Zip	(b)(6)
*Phone:	317-873-1833(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX
FAX:	317-873-2966		
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:	317-873-1833(XXX-XXX-XXXX)
*Today's Date:	12/02/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 12/02/2009

Verified:yes

Reviewed:yes

Date Entered: 03/15/2010

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.<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: AIV10173
 Product Code: 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 Vanguard Plus 5 L4	189	A940106	<input checked="" type="checkbox"/> Combination
2 Bronchicine CAe	189	A941614B	<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 1 ml	SQ	L shoulder	22	11/25/2009
2 1 ml	SQ	D shoulders	22	11/25/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/25/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: facial angioedema noted approximately 6 hours after vaccination. Treated with diphenhydramine 1 mg/kg IM and prednisolone 1 mg/kg subcutaneous	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	6 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:	13575 Twilight Perdue	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Shih tzu	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos):	3 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): 1st vaccination at different vet clinic 9/28/09 DHPP+Cv brand unknown			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Town & Country Veterinary Clinic 1605 North Franklin Street	Address:	(b)(6)
City:	Christiansburg	City:	(b)(6)
State:	VA	State:	VA
Zip:	24073	Zip:	(b)(6)
*Phone:	540-382-5042(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX
FAX:	540-382-6102		
E-mail:	drdesireet@hotmail.com	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:	540-382-5042(XXX-XXX-XXXX)
*Today's Date:	11/25/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 11/25/2009

Verified:yes

Reviewed:yes

Date Entered: 03/15/2010

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. <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: AIV10171

Product Code: 2668.00

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard L4	189	A944233A	<input checked="" type="checkbox"/> Bacterial
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L shoulder	25	11/07/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/07/2009
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: patient began vomiting 2 hrs post vax. Also became lethargic for 24-48 hours post vax. owner called 72 hours after vaccine and reported patient doing well and no longer lethargic.	

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 without treatment
Other:	

Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Lab	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0
Neutered: <input checked="" type="checkbox"/> No	
Age (i.e., 2 yrs or 2 mos): 3 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): 1 week prior to leptovaccine patient had received his DHPP #3.	

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Charlottesville Veterinary Hospital 865 Rio East Court	Address:	(b)(6)
City:	Charlottesville	City:	(b)(6)
State:	VA	State:	VA
Zip:	22901	Zip:	(b)(6)
*Phone:	434-973-5331(XXX-XXX-XXXX)	Phone:	(b)(6) XX-XXX-XXXX)
FAX:	434-973-4761		
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:	434-973-5331(XXX-XXX-XXXX)
*Today's Date:	11/23/2009(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: 11/24/2009

Verified:yes

Reviewed:yes

Date Entered: 03/15/2010

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: AIV10169

Product Code: 2100.02 47L9.20

*** 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 Bronchicine	189	A941614C	<input checked="" type="checkbox"/> Bacterial
2 Vanguard Plus	189	A943335	<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			11/14/2009
2 1 ml	SQ			11/14/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Non-veterinarian
*Date of Product Use:(MM/DD/YYYY)	11/14/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
Explain the event and any treatment in a concise paragraph: Vaccination	
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:	id30926date111409	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"/> Not Listed	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Not Listed		
Age (i.e., 2 yrs or 2 mos):	16 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): vaccination			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Animal Hospital of Redondo Beach 820 Torrance Blvd	Address:	(b)(6)
City:	Redondo Beach	City:	
State:	CA	State:	
Zip:	90277	Zip:	
*Phone:	310-540-9044(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	310540-1667		
E-mail:	leom@ahorb.com	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:	310-540-9044(XXX-XXX-XXXX)
*Today's Date:	11/20/2009(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Other
Other: Practice Manager

Submit

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

Date Received: 11/20/2009

Verified: yes

Reviewed: yes

Date Entered: 03/15/2010

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: AIV10168

Product Code: 2668.05

*** 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 LeptoVax 4	112	045155A	<input checked="" type="checkbox"/> Bacterial
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 fore		11/03/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/03/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: Before administering vaccine patient was premedicated with 2mg/kg Benadryl. Approximately 1 hr. post vaccination the patient's left fore limb began to swell. We gave Dexamethasone SP 0.2mg/kg 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)	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: Boston Terrier	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos): 1 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):	

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name:	
Address: Univ. of TN Veterinary Hospital 2407 River Drive		Address:	
City: Knoxville		City:	
State: TN		State:	
Zip: 37996		Zip:	
*Phone: 865-974-8387 (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:	865-974-8387 (XXX-XXX-XXXX)
*Today's Date:	11/20/2009 (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: 11/20/2009

Verified:yes

Reviewed:yes

Date Entered: 03/15/2010

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. <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: AIV10167

Product Code: 1905.23 2100.02 13D1.29 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 Imrab 3 TF	298	18095A	<input checked="" type="checkbox"/> Viral
2 Bronchicine CAe	189	A943582B	<input checked="" type="checkbox"/> Bacterial
3 Duramune Max 5	112	916144A	<input checked="" type="checkbox"/> Viral
4 CvK/LCI-GP	112	094238B	<input checked="" type="checkbox"/> Bacterial

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR	22	11/20/2009
2 1 ml	SQ	RR	22	11/20/2009
3 1 ml	SQ	LR	22	11/20/2009
4 1 ml	SQ	LR	22	11/20/2009

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/20/2009
Concurrent Drugs or Procedures:	Annual exam

Event Information

* Event description:	<input checked="" type="checkbox"/> Some other event - Describe Below
Explain the event and any treatment in a concise paragraph: Painful, Shaking	
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:	at home

Animal Information

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

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Suburban Animal Clinic 640 North Wilson Road		Address: (b)(6)	
City: Columbus		City: (b)(6)	
State: OH		State: OH	
Zip: 43204		Zip: (b)(6)	
*Phone: 614-276-5479(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:	614-276-5479(XXX-XXX-XXXX)
*Today's Date:	11/20/2009(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Not Listed
Other: Vet Asssistant

Submit

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

Date Received: 11/21/2009

Verified: yes

Reviewed: yes

Date Entered: 03/15/2010

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. <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: Valley Veterinary Hospital 3210 Main Avenue		Address:	
City: Fargo		City: (b)(6)	
State: ND		State: ND	
Zip: 58103		Zip:	
*Phone: 701-232-3391(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: Vet Tech

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: AIV10160

Product Code: 46E5.21 2100.02 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 LeptoVax 4/C	112	648111A	<input checked="" type="checkbox"/> Bacterial
2 Bronchicine CAe	189	A943582B	<input checked="" type="checkbox"/> Combination
3 Duramune Adult 3	112	1867115A	<input checked="" type="checkbox"/> Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip	22	11/18/2009
2 1 ml	SQ	R shoulder	22	11/18/2009
3 1 ml	SQ	L hip	22	11/18/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/18/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: about 2 mins after vaccine, owner called very lethargic, listless. 10 mins after that owner called and dog now vomiting. came to clinic wobbly, mm dusky, weak temp 99.9. 0.5 ml benadryl IM, 0.3 ml pepcid SQ, 2 somlnomos SQ 02 via mask. 10 mins later mm light pink, gave to owner, left 20 mins later.	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	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:	Maggie	For animals handled in a group (herd, litter, etc.)
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):		Number affected: 1
Breed:	Mini Schnauzer	Number vaccinated: 1
Sex:	<input checked="" type="checkbox"/> Female	Number dead: 0
Neutered:	<input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):	5 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Suburban Animal Clinic 640 North Wilson Road	Address:	(b)(6)
City:	Columbus	City:	(b)(6)
State:	OH	State:	OH
Zip:	43204	Zip:	(b)(6)
*Phone:	614-276-5479(XXX-XXX-XXXX)	Phone:	(b)(6) XX-XXX-XXXX
FAX:	614-276-9989		
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:	614-276-5479(XXX-XXX-XXXX)

*Today's Date:	11/19/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

[Submit](#)

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

Date Received: 11/19/2009

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: AIV10159
 Product Code: 1905.21 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 Rabvac 3	112	1215326A	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916490A	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/16/2009
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: Dog vomited and collapsed, pale mucous membranes; vet gave 2mg/kg IM benadryl, 0.25mg/kg Dex SP 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)	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:	Pet is alive 23 hrs. later, seems okay but slightly lethargic

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): 16 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Pet was acquired 14 months ago through rescue group and received all puppy vaccinations per schedule last year. Yesterdays vaccines were annual exam and vaccines. No adverse reaction last year. Otherwise healthy pet.		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name	(b)(6)
Address: Riverdale Veterinary Group 3607 Riverdale Avenue		Address	(b)(6)
City: Bronx		City	(b)(6)
State: NY		State: NY	
Zip: 10463		Zip	(b)(6)
*Phone: 718-796-8387(XXX-XXX-XXXX)		Phone	(b)(6) XX
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

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

Submit

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

Date Received: 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: AIV10157

Product Code: 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 Duramune Max 5	112	916492A	<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	interscap	??	10/27/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Non-veterinarian
*Date of Product Use:(MM/DD/YYYY)	10/27/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description: <input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: 2.5 cm x 2.5 cm firm mass in area of vaccine 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)	possibly weeks
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	monitoring, unsure of resolution at this time

Animal Information

Case Identification:	Auggie	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 Ret.	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos):	2 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): acquired from breeder ~ 10/31/2009			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	Mount Hood Veterinary Specialists 21920 SE Stark Street	Address:	
City:	Gresham	City:	
State:	OR	State:	
Zip:	97030	Zip:	
*Phone:	503-665-1109(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:	503-665-1109(XXX-XXX-XXXX)
*Today's Date:	11/16/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 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: 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)(6)	Name:	
Address:	VCA Kirkwood Animal Hospital 1501 Capitol Trl	Address:	
City:	Newark	City:	
State:	DE	State:	
Zip:	19711-5715	Zip:	
*Phone:	302-737-1098(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)
	302-737-1098(XXX-XXX-XXXX)

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

Submit

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

Date Received: 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: AIV10152

Product Code: 1905.21 1331.20 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 Rabvac 3	112	1215317A	<input checked="" type="checkbox"/> Viral
2 Duramune Adult 3	112	1867115A	<input checked="" type="checkbox"/> Viral
3 Bronchicine	189	A943582A	<input checked="" type="checkbox"/> Bacterial
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hind	23	11/11/2009
2 1 ml	SQ	L front	23	11/11/2009
3 1 ml	SQ	R front	23	11/11/2009
4				

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

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: facial edema; swelling occurred 3 hrs after vaccines. no vomiting or breathing difficulty. gave 1.3 ml benadryl IM, 3.5 ml, dex SP IM.	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	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: Rhodesian Ridgeback	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: RiverCity Animal Hospital 310 North Herborn Place		Address: (b)(6)	
City: Postfalls		City: (b)(6)	
State: ID		State: ID	
Zip: 83854		Zip: (b)(6)	
*Phone: 208-777-9178(XXX-XXX-XXXX)		Phone: (b)(6) (XXX-XXX-XXXX)	
FAX: 208-773-4558			
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:	208-777-9178(XXX-XXX-XXXX)
*Today's Date:	11/11/2009(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: 11/12/2009

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: AIV10151

Product Code: 1905.23 13D1.22 1081.00

*** Required Fields**

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Imrab 3 TF	298	18096C	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A940898A	<input checked="" type="checkbox"/> Viral
3 Vanguard B (IN)	112	110269C	<input checked="" type="checkbox"/> Bacterial
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	10/30/2009
2 1 ml	SQ	R forelimb	25	10/30/2009
3 1 ml	IN	intranasal	na	10/30/2009
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:	ear cleaning with epiotic advanced. topical application of panalog ointment in ears.

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: a raised firm mass effect of ~1.7 cm in diameter was noted by the owner 6 days following vaccination for rabies. mass	

is present on right pelvic limb at approximate vaccination site.

<p align="center">If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.</p>	
Onset (How long after product use did the event begin?) (Include Units:mins, hrs, days, wks, mos, yrs)	approx. 6 days
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Did not recover
Other:	mass is still present

Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog) (Other Species):	Number in group: 1
Breed: Labrador cross	Number affected: 1
Sex: <input checked="" type="checkbox"/> Male	Number vaccinated: 1
Neutered: <input checked="" type="checkbox"/> Yes	Number dead: 0
Age (i.e., 2 yrs or 2 mos): 1 - 1.5 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): acquired 1 year ago. received initial vaccination at that time. no major medical problems or concerns indoor/outdoor pet. commercial diet. 4 dogs total in household/1 cat. owned by vet technician.	

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: VCA Santa Anita Animal Hospital 245 West Duarte Road		Address: (b)(6)	
City: Monrovia		City: (b)(6)	
State: CA		State: CA	
Zip: 91016		Zip: (b)(6)	
*Phone: 626-359-3281(XXX-XXX-XXXX)		Phone: (b)(6) XX-XXX-XXXX)	
FAX: 626-305-0512			
E-mail: j-najarian@hotmail.com		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:	626-359-3281(XXX-XXX-XXXX)
*Today's Date:	11/11/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 11/13/2009

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: 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)(6)		Name	(b)(6)
Address: Webster Groves Animal Hospital 8028 Big Bend Blvd.		Address	(b)(6)
City: Webster Groves		City	(b)(6)
State: MO		State:MO	
Zip:63119		Zip	(b)(6)
*Phone:314-960-4310(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:	314-960-4310(XXX-XXX-XXXX)
*Today's Date:	11/09/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 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: AIV10145

Product Code: 13D1.22

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard Plus 5	189	A940425	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	shoulder blade		11/02/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/02/2009
Concurrent Drugs or Procedures:	nothing

Event Information

* Event description: <input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: 12 hrs post vax, wet feet, lethargy, 4 mg dex post sweating, 30 mg prednisone daily.
If this adverse event involves a possible lack of efficacy with a rabies product please

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	12 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> 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: Corgi Mix	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): 1.5 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: Low Cost Spay & Neuter 1520 Northern Avenue		Address: (b)(6)	
City: Kingman		City: (b)(6)	
State: AZ		State: AZ	
Zip: 86409		Zip: (b)(6)	
*Phone: 928-692-5226(XXX-XXX-XXXX)		Phone: (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
*Today's Date:	11/05/2009(MM/DD/YYYY)
Relationship to animal:	

<input type="checkbox"/>	Owner
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: Page

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: AIV10142
 Product Code: 2668.05 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 LeptoVax 4	112	045154A	<input checked="" type="checkbox"/> Bacterial
2 Galaxy DA2PPvL	165A	212384A	<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 hip	25	10/30/2009
2 1 ml	SQ	L hip	25	10/30/2009
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:	just vacc

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: Owner called several days later, reported that the left hip swelled up quite a bit and pt was very uncomfortable to the touch for the first 2 days. After that, seemed to resolve quickly. At time of call from Owner, pt was still a little sore, but there was no swelling. Owner declined any treatment at this time, but will pretreat before future 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)	within 3-4 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Low
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

Animal Information

Case Identification:	6128-1	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:	Catahoula Mix	Number vaccinated: 1	
Sex:	<input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	10 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Owner obtained from humane society. HW negative, spayed at shelter, bordetella on 10/11/2009, dhpp on 10/11/09, rabies on 10/17/2009. Was treated for infectious tracheobronchitis on 10/22/2009 with speedy uncomplicated recovery.			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Oak Hill Veterinary Clinic, Inc. 7101 Hwy 71, West, Suite A-8	Address:	
City:	Austin	City:	
State:	TX	State:	
Zip:	78735	Zip:	
*Phone:	512-288-1016(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	512-288-1322		
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:	512-288-1016(XXX-XXX-XXXX)

*Today's Date:	11/04/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 11/04/2009

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: AIV10137

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	916384A	<input checked="" type="checkbox"/> Viral
2 LCI-GP	112	350253A	<input checked="" type="checkbox"/> Bacterial
3 Imrab 1 TF	298	22021C	<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	L shoulder	23	10/30/2009
2 1 ml	SQ	R shoulder	23	10/30/2009
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: Red itchy eyes, rubbing face	
If this adverse event involves a possible lack of efficacy with a rabies product please	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	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:	7926	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:	Schnoodle	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	2 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	Animal Medical Clinic 234 Snelling Avenue South	Address:	
City:	St. Paul	City:	
State:	MN	State:	
Zip:	55105	Zip:	
*Phone:	651-690-1564(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	651-698-9595		
E-mail:	amc234@goldengate.net	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:	651-690-1564(XXX-XXX-XXXX)
*Today's Date:	11/03/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 11/03/2009

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. [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: AIV10136

Product Code: 1905.23 13D1.29 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 Imrab 3 TF	298	18095A	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916434A	<input checked="" type="checkbox"/> Viral
3 CvK/LCI-GP	112	094236A	<input checked="" type="checkbox"/> Combination
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip	22	11/03/2009
2 1 ml	SQ	L hip	22	11/03/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/03/2009
Concurrent Drugs or Procedures:	Clavamox tabs 250 mg #14 IPOBID

Event Information

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

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	4 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	not listed

Animal Information

Case Identification:	Toeby	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:	Bernese Mountain	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Not Listed		
Age (i.e., 2 yrs or 2 mos):	4 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:	Suburban Animal Clinic 640 North Wilson Road	Address:	(b)(6)
City:	Columbus	City:	(b)(6)
State:	OH	State:	OH
Zip:	43204	Zip:	(b)(6)
*Phone:	614-276-5479(XXX-XXX-XXXX)	Phone:	(b)(6) (XXX-XXX-XXXX)
FAX:	614-276-9989		
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:	614-276-5479(XXX-XXX-XXXX)
*Today's Date:	11/03/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 11/03/2009

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: AIV10135

Product Code: 13D1.29 2668.05 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 Duramune Max 5	112	916453A	<input checked="" type="checkbox"/> Viral
2 LCI-GP	112	350259A	<input checked="" type="checkbox"/> Bacterial
3 Bronchicine	189	A831816C	<input checked="" type="checkbox"/> Bacterial
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R cervical	25	10/15/2009
2				
3 1 ml	SQ	L cervical	25	10/15/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/15/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: immediate anaphylactic reaction. started vomiting immediately, multiple time. m. membranes pale, greyish poor crt. sluggish heart rate, entered for O2 therapy IV cath & fluids. benadryl 50 mg IM, ?? 100 mg & epiphrene 1:1000.	

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"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Bassett Hound	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 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: MacDonald Veterinary Hospital Inc. 267 Cottage Grove		Address: (b)(6)	
City: Bloomfield		City: (b)(6)	
State: CT		State: CT	
Zip: 06002		Zip: (b)(6)	
*Phone: 860-242-5506(XXX-XXX-XXXX)		Phone: (b)(6) XXX-XXX-XXXX	
FAX: 860-242-6656			
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:	860-242-5506(XXX-XXX-XXXX)
*Today's Date:	11/03/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 11/05/2009

Verified:yes

Reviewed:yes

Date Entered: 02/11/2010

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: 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: Crests Hill Dog & Cat Clinic 2351 Copper Court		Address	(b)(6)
City: Bolingbrook		City	(b)(6)
State: IL		State: IL	
Zip: 60435		Zip: (b)(6)	
*Phone: 815-744-3540(XXX-XXX-XXXX)		Phone: (b)(6) (XXX-XXX-XXXX)	
FAX: 815-744-3765			
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:	10/26/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 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: AIV10125

Product Code: 2668.05

* 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 LeptoVax 4	112	045151A	<input checked="" type="checkbox"/> Bacterial
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	LH leg	22	10/12/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/12/2009
Concurrent Drugs or Procedures:	50 mg doxycycline

Event Information

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

Explain the event and any treatment in a concise paragraph:
 Rascal came in for a first lepto booster on 10/12/09. The other dogs in the family have high lepto titers and one had to be hospitalized. Rascal had negative titers. Approximately 15-20 minutes after receiving the vaccine, Rascal vomited in the owner's car on the way home and also became extremely restless. When Rascal came into our practice, he

was hypoxic and his mucous membranes and tongue were a bluish color and Rascal also had "chewing gum" fits. We placed Rascal on oxygen and then gave 0.5 mLs of Benadryl IM and 0.75 mLs of Dexium-SP IV. Rascal's condition improved and we released him to the owner several hours later.

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

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

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

*Outcome (select one): Recovered with treatment

Other:

Animal Information

Case Identification:	4590	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):	13 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Other 2 dogs in household have positive leptotiters but Rascal had negative leptotiters so we were starting him on the leptotiters for protection. He was also placed on prophylactic Doxycycline on 10/9/2009 by another veterinarian in the practice			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Horton Animal Hospital-Northeast 2608 Paris Road	Address:	(b)(6)
City:	Columbia	City:	(b)(6)
State:	MO	State:	MO
Zip:	65202	Zip:	(b)(6)
*Phone:	573-474-9508(XXX-XXX-XXXX)	Phone:	(b)(6) XX-XXX-XXXX
FAX:	573-474-9554		
E-mail:		E-mail:	

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

*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number:	573-474-9508(XXX-XXX-XXXX)
*Today's Date:	10/22/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 10/22/2009

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: 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: Countryside Animal Hospital 8701 South Rural Road		Address:	
City: Tempe		City:	
State: AZ		State:	
Zip: 85284-2345		Zip:	
*Phone: 480-775-9966(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:	480-775-9966(XXX-XXX-XXXX)
*Today's Date:	10/20/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 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: AIV10123

Product Code: 2100.02 1905.23 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 Bronchicine CAe	189	A941614B	<input checked="" type="checkbox"/> Bacterial
2 Imrab 3 TF	298	18097A	<input checked="" type="checkbox"/> Viral
3 Duramune Max 5	112	916481A	<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	L shoulder	23	10/07/2009
2 1 ml	SQ	R hip	23	10/07/2009
3 1 ml	SQ	R shoulder	23	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:	Had dental prophylaxis several hours before vaccines were administered. Drugs used: Ketamine, diazepam, acepromazine.

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph:	

On 10/15/2009 owner noticed firm swelling near L shoulder. ~2cm firm SQ swelling with edematous tissue extending a few cm ventral to swelling. Swelling improved with IM Dexamethasone SP and oral Benadryl.

<p style="text-align: center;">If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.</p>	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 week and 1 day
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

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: Terrier Mix	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 7 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: Zionsville Animal Hospital 1305 Parkway Drive		Address:	
City: Zionsville		City:	
State: IN		State:	
Zip: 46077-1954		Zip:	
*Phone: 317-873-1833 (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:	317-873-1833(XXX-XXX-XXXX)
*Today's Date:	10/20/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 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: AIV10112

Product Code: 2668.00

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard L4	189	A839157B	<input checked="" type="checkbox"/> Bacterial
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hip	25	10/08/2009
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:	distemper, parvo, PI2 combo given over shoulder

Event Information

* Event description: <input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: soft tissue swelling 1.5" diameter over left flank.

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

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

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: Yorkie	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): 8 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): ?? history of allergies		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	Charlottesville Veterinary Hospital 865 Rio East Court	Address	(b)(6)
City:	Charlottesville	City	(b)(6)
State:	VA	State:	VA
Zip:	22901	Zip	(b)(6)
*Phone:	434-973-4341(XXX-XXX-XXXX)	Phone	(b)(6) XX-XXX-XXXX)
FAX:	434-973-8118		
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:	434-973-4341(XXX-XXX-XXXX)
*Today's Date:	10/12/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 10/16/2009

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: AIV10111

Product Code: 2668.00

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard L4	189	A839157B	<input checked="" type="checkbox"/> Bacterial
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hip	25	10/08/2009
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:	distemper, parvo, pi2, vax combo given over shoulder

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: soft tissue swelling 1.5 diameter over left flank.	

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

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

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: Yorkie	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): 8 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): canine - history of allergies		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name	(b)(6)
Address: Charlottesville Veterinary Hospital 865 Rio East Court		Address	(b)(6)
City: Charlottesville		City	(b)(6)
State: VA		State: VA	
Zip: 22901		Zip	(b)(6)
*Phone: 434-973-4341 (XXX-XXX-XXXX)		Phone	(b)(6) XX-XXX-XXXX
FAX: 434-973-9118			
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:	434-973-4341 (XXX-XXX-XXXX)
*Today's Date:	10/12/2006 (MM/DD/YYYY)

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

Submit

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

Date Received: 10/27/2009

Verified:yes

Reviewed:yes

Date Entered: 02/01/2010

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: AIV10109

Product Code: 13D1.20 2668.00 2126.00

*** Required Fields**

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Proguard-5	286	04008012B/07408031	<input checked="" type="checkbox"/> Viral
2 Vanguard L4	189		<input checked="" type="checkbox"/> Bacterial
3 LymeVax	112	229198A	<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	unknown	25	10/08/2009
2 1 ml	SQ	unknown	25	10/08/2009
3 1 ml	SQ	unknown	25	10/08/2009
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"/> Some other event - Describe Below
Explain the event and any treatment in a concise paragraph: fever of 106.5 48 hours later - resolved with NSAID and antibiotic	
If this adverse event involves a possible lack of efficacy with a rabies product please	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	within 48 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:	Riddick	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:	GSD	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		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): pet indoor			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Animal Care Clinic 504 South Randall Road	Address:	(b)(6)
City:	South Elgin	City:	(b)(6)
State:	IL	State:	IL
Zip:	60177	Zip:	(b)(6)
*Phone:	847-742-5700(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:	847-742-5700(XXX-XXX-XXXX)
*Today's Date:	10/08/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 10/08/2009

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: AIV10108

Product Code: 13D1.22 2100.02 14P5.20

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard Plus 5	189	A941982C	<input checked="" type="checkbox"/> Viral
2 Bronchicine	189	A941614C	<input checked="" type="checkbox"/> Bacterial
3 Vangaard CV	189	A948651A	<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	10/01/2009
2 1 ml	SQ	Shoulder	22	10/01/2009
3 1 ml	SQ	LR	22	10/01/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/01/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: approx 7 min after vx given puppy turned blue and had a seizure. Gave dex IM and puppy became alert and responsive. Then crashed and had serosang. fluid from lungs. Propoflo IV then intubated, gave additional dose of dex, lasix and epi. Transferred to ER clinic. After 24 hrs then o euthanized	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	7 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:	euthanized

Animal Information

Case Identification:	Luca Witherington	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"/> No		
Age (i.e., 2 yrs or 2 mos):	11 wks		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): O had dog for 3 days. Breeder vaccinated with DHPP from breeder approx 3 weeks prior			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	VCA Eagle River Animal Hospital 11710 Business Blvd	Address:	(b)(6)
City:	Eagle River	City:	(b)(6)
State:	AK	State:	AK
Zip:	99577	Zip:	99577
*Phone:	907-694-3800(XXX-XXX-XXXX)	Phone:	(b)(6) XX-XXX-XXXX
FAX:	9076942918		
E-mail:	drlaurabailey@hotmail.com	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:	907-694-3800(XXX-XXX-XXXX)

*Today's Date:	10/07/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

[Submit](#)

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

Date Received: 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: 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.

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?): 30 mins
(Include Units:mins, hrs, days, wks, mos, yrs)

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

*Outcome (select one): 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		

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 leptovaccine. 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.

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	Cypress Veterinary Hospital 2037 Main Street	Address:	
City:	Oakley	City:	
State:	CA	State:	
Zip:	94561	Zip:	
*Phone:	925-625-5330(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

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

*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number:	925-625-5330(XXX-XXX-XXXX)
*Today's Date:	10/07/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 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: AIV10106

Product Code: 13D1.29 2668.05

*** 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	916456A	<input checked="" type="checkbox"/> Viral
2 LeptoVax 4	112	045154A	<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 1 ml	SQ	R shoulder	23	10/02/2009
2 1 ml	SQ	L shoulder	23	10/02/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/02/2009
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: Within 2 minutes of vaccinating, the dog suddenly urinated, became very quiet, then salivated and mm were very pale. Administered IV fluids, DexNaPhos, and Diphenhydramine. She responded quickly and we did not need to give any epinephrine.	

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 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: Ali Wolff	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 mix	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): 13 wks		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Obtained from a friend. Kept mostly indoors. On lams puppy food. Had a DHPP vaccine elsewhere 1 month earlier (unknown brand).		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: All Paws Animal Hospital 5225 Excelsior Blvd.		Address: (b)(6)	
City: St. Louis Park		City: (b)(6)	
State: MN		State: MN	
Zip: 55416		Zip: (b)(6)	
*Phone: 952-848-0913(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:	952-848-0913(XXX-XXX-XXXX)

*Today's Date:	10/06/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 10/06/2009

Verified:yes

Reviewed:yes

Date Entered: 02/01/2010

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: AIV10104

Product Code: 13D1.22

*** Required Fields**

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard Plus 5	189	A941582	<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	Over shoulder blade	23	10/01/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/02/2009
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: 10 min after vx was given dog came back mm pale, bradychardic,lethargic,CRT >2 heartrate at 56. Treated with I.V. fluids, O2, IV Dex 26mg, Diphenhydramine 40mg IM. Took 45 min. to stalabilze. Sent home with Pred 20mg 1/2 last night and 1/2 tab a.m.	

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 :Shih Tzu mix	Number vaccinated:1
Sex: <input checked="" type="checkbox"/> Male	Number dead:0
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos):2 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): vx up to date on dhpp, rabies, bordetella never rx before, no medical problems,inside dog, diet unsure.	

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Heritage Animal Hospital Ltd. W6415 Greenville Drive		Address: (b)(6)	
City: Greenville		City: (b)(6)	
State: WI		State:WI	
Zip:54942		Zip: (b)(6)	
*Phone:920-757-0407(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"/> Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	920-757-0407(XXX-XXX-XXXX)

*Today's Date:	10/02/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	vet tech

Submit

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

Date Received: 10/02/2009

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: AIV10103

Product Code: 2668.05

*** 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 LeptoVax 4	112	045155A	<input checked="" type="checkbox"/> Bacterial
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)	10/01/2009
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 had Benadryl as pre-medication. 8-9 hours after vaccine injection patient had hives on face, head, and rear legs. Face was also swollen and whole body was itchy	

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)	8-9 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: 1	
(Other Species):	Number affected: 1	
Breed: Dachshund	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name:	
Address: Univ. of TN, College of Vet Med 2407 River Drive		Address:	
City: Knoxville		City:	
State: TN		State:	
Zip: 37996		Zip:	
*Phone: 865-974-8387 (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:	865-974-8387 (XXX-XXX-XXXX)
*Today's Date:	10/02/2009 (MM/DD/YYYY)

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

Submit

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

Date Received: 10/02/2009

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

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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: AIV10102

Product Code: 13D1.29 1905.23

*** 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	916441A	<input checked="" type="checkbox"/> Viral
2 Rabvac 3 TF	112	873176A	<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	over L hip	25	10/01/2009
2 1 ml	SQ	over R hip	25	10/01/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/01/2009
Concurrent Drugs or Procedures:	

Event Information

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

Explain the event and any treatment in a concise paragraph:
 This Pug was vaccinated with both Fort Dodge Duramune Max 5 and Rabvac 3. Five minutes after the vaccinations the patient collapsed and became pale. She was treated via IV catheter with 70mg prednisolone sodium succinate, 15mg diphenhydramine IM, flow-by oxygen and IV lactated ringers. Response to this treatment was good. She still

had some facial swelling at 7 hours when she was discharged, and owner was advised to continue oral diphenhydramine 25mg every 12 hours at home due to facial pruritus.

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

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

Animal Information

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

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	Radnor Veterinary Hospital 112 N Aberdeen Avenue	Address:	
City:	Wayne	City:	
State:	PA	State:	
Zip:	19087	Zip:	
*Phone:	610-687-1550(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	610-687-6709		
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:	610-687-1550(XXX-XXX-XXXX)
*Today's Date:	10/01/2009(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: 10/01/2009

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: AIV10101
 Product Code: 2126.R0 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 Recombitek Lyme	298	42149	<input checked="" type="checkbox"/> Recombinant
2 Duramune Max 5	112	916467A	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L shoulder	24	09/30/2009
2 1 ml	SQ	R shoulder	24	09/30/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/30/2009
Concurrent Drugs or Procedures:	

Event Information

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

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

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

Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog) (Other Species):	Number in group:	1
Breed: Lab Retriever	Number affected:	1
Sex: <input checked="" type="checkbox"/> Female	Number vaccinated:	1
Neutered: <input checked="" type="checkbox"/> No	Number dead:	0
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:	(b)(6)
Address:	Apple Valley Animal Hospital 1207 Cedar Creek Grade	Address:	(b)(6)
City:	Winchester	City:	(b)(6)
State:	VA	State:	VA
Zip:	22602	Zip:	(b)(6)
*Phone:	540-678-0202(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	540-678-0419		
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:	540-678-0202(XXX-XXX-XXXX)
*Today's Date:	10/01/2009(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: 10/01/2009

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: AIV10099

Product Code: 2668.00

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard L4	189	A839157A	<input checked="" type="checkbox"/> Bacterial
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	L shoulder	25	09/21/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/21/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description: <input checked="" type="checkbox"/> Some other event - Describe Below
Explain the event and any treatment in a concise paragraph: She had a short seizure the next day after getting the vaccine.
If this adverse event involves a possible lack of efficacy with a rabies product please

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	24 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Low
*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: Golden retriever	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 7 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name:	
Address: Bluffs of Red Wing - A Clinic for Pets 712 State Street South		Address:	
City: Waseca		City:	
State: MN		State:	
Zip: 56093-3037		Zip:	
*Phone: 651-388-1103(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:	651-388-1103(XXX-XXX-XXXX)
*Today's Date:	09/26/2009(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: 09/26/2009

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: AIV10092

Product Code: 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 Duramune Max 5	112	916419A	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L shoulder	23	09/18/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/18/2009
Concurrent Drugs or Procedures:	Strongid T dewormer

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Patient became lethargic and vomited before leaving exam room. Gave 0.5 ml benadryl IM.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

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

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

Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog) (Other Species):	Number in group: 1
Breed: Pekingese Pomeranian X	Number affected: 1
Sex: <input checked="" type="checkbox"/> Female	Number vaccinated: 1
Neutered: <input checked="" type="checkbox"/> No	Number dead: 0
Age (i.e., 2 yrs or 2 mos): 8 wks	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): no previous vaccinations	

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: River City Animal Hospital 310 North Herborn Place		Address: (b)(6)	
City: Post Falls		City: (b)(6)	
State: ID		State: ID	
Zip: 83854		Zip: (b)(6)	
*Phone: 208-777-9178(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:	208-777-9178(XXX-XXX-XXXX)
*Today's Date:	09/23/2009(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Other
Other:vet tech

Submit

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

Date Received: 09/23/2009

Verified:yes

Reviewed:yes

Date Entered: 01/19/2010

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: AIV10091

Product Code: 1331.20 2668.05 1905.23

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Adult 3	112	1867112A	<input checked="" type="checkbox"/> Viral
2 LCI-GP	112	250255A	<input checked="" type="checkbox"/> Bacterial
3 Rabvac 3 TF	112	873181A	<input checked="" type="checkbox"/> Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	22	09/02/2009
2 1 ml	SQ	R shoulder	22	09/02/2009
3 1 ml	SQ	R hind	22	09/02/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/02/2009
Concurrent Drugs or Procedures:	Heartworm prevention

Event Information

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

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

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

Animal Information

Case Identification:	2009-US-05336	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):	15 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Indoor dog, on Heartgard, fed Rajal Canin.			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	River Road Veterinary Hospital, Inc. 176 River Road	Address	(b)(6)
City:	Andover	City	(b)(6)
State:	MA	State:	MA
Zip:	01810	Zip	(b)(6)
*Phone:	978-687-8400(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX
FAX:	978-687-2025		
E-mail:	www.riverroadveterinaryhospital.com	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:	978-687-8400(XXX-XXX-XXXX)
*Today's Date:	09/23/2009(MM/DD/YYYY)
Relationship to animal:	

<input type="checkbox"/> Other
Other:vet tech

Submit

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

Date Received: 09/23/2009

Verified:yes

Reviewed:yes

Date Entered: 01/19/2010

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: AIV10088

Product Code: 47K1.20 2100.02 2126.00

*** Required Fields**

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard Plus 5/L4	189		<input checked="" type="checkbox"/> Combination
2 Bronchicine	189		<input checked="" type="checkbox"/> Bacterial
3 LymeVax	112		<input checked="" type="checkbox"/> Bacterial
4			

Administration of products.

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

Administered by: <input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY) 08/27/2009
Concurrent Drugs or Procedures: none

Event Information

* Event description: <input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: Pet cam in for lameness, inappetence, lethargy, pain post vaccine. Given Rimadyl SQ 0.8 ml @ the time suspect rxn to 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)	14 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	

Animal Information

Case Identification:	Jessy	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:	Border Collie	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):	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:	Westfield Veterinary Group 562 Springfield Avenue	Address:	
City:	Westfield	City:	
State:	NJ	State:	
Zip:	07090	Zip:	
*Phone:	908-232-1048(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:	908-232-1048(XXX-XXX-XXXX)
*Today's Date:	08/28/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 09/29/2009

Verified:yes

Reviewed:yes

Date Entered: 01/15/2010

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: AIV10087

Product Code: 13D1.29 1081.00 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 Duramune Max 5	112	916465A	<input checked="" type="checkbox"/> Viral
2 Vanguard B (IN)	189	110268C	<input checked="" type="checkbox"/> Bacterial
3 Duramune Cv-K		145268A	<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	23	09/15/2009
2 1 ml	IN	Intranasal	NA	09/15/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/15/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: reactions in the past pretreated with benadryl came back with scratching at the ears	
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: 8740	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		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name:	
Address: Animal Medical Clinic 234 Snelling Avenue South		Address:	
City: St. Paul		City:	
State: MN		State:	
Zip: 55105		Zip:	
*Phone: 651-690-1564(XXX-XXX-XXXX)		Phone: (XXX-XXX-XXXX)	
FAX: 651-698-9595			
E-mail: amc234@goldengate.net		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:	651-690-1564(XXX-XXX-XXXX)
*Today's Date:	09/19/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 09/19/2009

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. [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: AIV10086

Product Code: 2668.05

* 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 LeptoVax 4	112		<input checked="" type="checkbox"/> Bacterial
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)	09/15/2009
Concurrent Drugs or Procedures:	also received Imrab 3

Event Information

* Event description: <input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Angioedema of face, muzzle, respiratory distress, twitching
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"/> 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: Pekingese	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 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): adopted approximately 1.5 wks ago from breeders in Alabama, no previous history of leptovaccine		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name:	
Address: U of TN, College of Vet Med 2407 River Drive		Address:	
City: Knoxville		City:	
State: TN		State:	
Zip: 37796		Zip:	
*Phone: 865-974-8387(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:	865-974-8387(XXX-XXX-XXXX)
*Today's Date:	09/18/2009(MM/DD/YYYY)
Relationship to animal:	

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

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. [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: AIV10085

Product Code: 13D1.29 46J9.25 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 Duramune Max 5	112	916434A	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5-CvK/4L	112		<input checked="" type="checkbox"/> Combination
3 Bronchicine	189	A835376C	<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	L hip	22	09/17/2009
2				
3 1 ml	SQ	R hip	22	
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:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: spt: nothing specific listed here	
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: Shih Tzu	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 5 yrs 9 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: Suburban Animal Clinic 640 North Wilson Road		Address: (b)(6)	
City: Columbus		City: (b)(6)	
State: OH		State: OH	
Zip: 43204		Zip: (b)(6)	
*Phone: 614-276-5479(XXX-XXX-XXXX)		Phone: (b)(6) XX-XXX-XXXX)	
FAX: 614-276-9989			
E-mail: info@suburbananimalclinic.com		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:	614-276-5479(XXX-XXX-XXXX)
*Today's Date:	09/18/2009(MM/DD/YYYY)
Relationship to animal:	

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

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. [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: AIV10083

Product Code: 2668.05

* 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 LeptoVax 4	112		<input checked="" type="checkbox"/> Bacterial
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)	08/01/2009
Concurrent Drugs or Procedures:	DAPP vacc

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: facial edema/swell & ?? puritis. reaction eventually resolved with antihistamine & steroid therapy.	
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 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: Max	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): 10 ??		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

Personal Information

Veterinarian		Owner	
*Name:		Name:	
Address:	Santa Cruz Veterinary Hospital 2585 Soquel Drive	Address:	
City:	Santa Cruz	City:	
State:	CA	State:	
Zip:	95065	Zip:	
*Phone:	831-475-5400(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:	831-475-5400(XXX-XXX-XXXX)
*Today's Date:	09/18/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 09/29/2009

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. <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: AIV10082

Product Code: 2668.05

*** 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 LeptoVax 4	112		<input checked="" type="checkbox"/> Bacterial
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)	09/08/2009
Concurrent Drugs or Procedures:	Rabies SQ & DAPP SQ

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: facial & pinna swelling & puritis, lasted about 12 -18 hrs. tx with oral Benadryl & 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)	several 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:	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 :	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):	6 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	Santa Cruz Veterinary Hospital 2585 Soquel Drive	Address:	
City:	Santa Cruz	City:	
State:	CA	State:	
Zip:	95065	Zip:	
*Phone:	831-475-5400(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	831-475-5400(XXX-XXX-XXXX)
*Today's Date:	09/18/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 09/29/2009

Verified:yes

Reviewed:yes

Date Entered: 01/15/2010

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: AIV10081

Product Code: 2668.05

* 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 LeptoVax 4	112		<input checked="" type="checkbox"/> Bacterial
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)	09/18/2009
Concurrent Drugs or Procedures:	DAPP

Event Information

* Event description: <input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: facial pruritis & swelling, lasted about 8 hrs. ?? just exposed to this vaccine - not prev. used.
If this adverse event involves a possible lack of efficacy with a rabies product please

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	6 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: 1
(Other Species):	Number affected: 1
Breed:	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: Santa Cruz Veterinary Hospital 2585 Soquel Drive		Address:	
City: Santa Cruz		City:	
State: CA		State:	
Zip: 95065		Zip:	
*Phone: 831-475-5400(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:	831-475-5400(XXX-XXX-XXXX)
*Today's Date:	09/18/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 09/29/2009

Verified:yes

Reviewed:yes

Date Entered: 01/15/2010

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: AIV10077

Product Code: 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 Durramune Max 5	112	1921107A	<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	Between shoulder blades	25	09/11/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/11/2009
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: Within 5 seconds of injection dog was yelping and scratching. Then 5 minutes later became lethargic, vomited twice, and had shallow respirations and pale mucous membranes.	

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 sec to 5 mins	
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High	
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment	
Other:		

Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1	
(Other Species):	Number affected: 1	
Breed: Yorkshire/Maltese mix	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos): 3 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Dog was aquired from breeder several weeks previous to presentation. Was normal on physical examination prior to vaccination. Puppy had received Pfizer Vangard Plus DHPP-C lot A837541 on 08/13/2009 by a different veterinary clinic.		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name:	
Address: Spartan Animal Hospital 4811 Larson Beach Road		Address:	
City: McFarland		City:	
State: WI		State:	
Zip: 53589		Zip:	
*Phone: 608-838-6115(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:	608-838-6115(XXX-XXX-XXXX)

*Today's Date:	09/15/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 09/15/2009

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.<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: AIV10073

Product Code: 1905.24 13D1.29 1081.00 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 Imrab 1 TF	298	22020B	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916465A	<input checked="" type="checkbox"/> Viral
3 Vanguard B (IN)	112	110268C	<input checked="" type="checkbox"/> Bacterial
4 Duramune Cv-K	112	145268A	<input checked="" type="checkbox"/> Viral

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip	23	09/11/2009
2 1 ml	SQ	L hip	23	09/11/2009
3 1 ml	IN	Intranasal	NA	09/11/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/11/2009
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, lethargic, slightly pale	
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: 8438	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: Rat Terrier/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): 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: Animal Medical Clinic 234 Snelling Avenue South		Address:	
City: St. Paul		City:	
State: MN		State:	
Zip: 55105		Zip:	
*Phone: 651-690-1564(XXX-XXX-XXXX)		Phone: (XXX-XXX-XXXX)	
FAX: 651-698-9595			
E-mail: amc234@goldengate.net		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:	651-690-1564(XXX-XXX-XXXX)
*Today's Date:	09/14/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 09/14/2009

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. [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: AIV10071

Product Code: 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 Duramune Adult 3	112	1867113A	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L shoulder	23	09/09/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/09/2009
Concurrent Drugs or Procedures:	gave 25 mg benadryl before vaccine

Event Information

* Event description: <input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: owner brought patient in for facial edema and hives. gave 8 mg Dex SP 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)	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: Boston 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): 6 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): facial edema reaction to DHPP since 2005	

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name	(b)(6)
Address: River City Animal Hospital 310 North Herborn Place		Address	(b)(6)
City: Post Falls		City	(b)(6)
State: ID		State: ID	
Zip: 83854		Zip	(b)(6)
*Phone: 208-777-9178(XXX-XXX-XXXX)		Phone	(b)(6) (X-XXX-XXXX)
FAX: 208-773-4558			
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:	208-777-9178(XXX-XXX-XXXX)
*Today's Date:	09/11/2009(MM/DD/YYYY)
Relationship to animal:	

<input type="checkbox"/> Other
Other:vet tech

Submit

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

Date Received: 09/11/2009

Verified:yes

Reviewed:yes

Date Entered: 12/22/2009

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: AIV10069

Product Code: 1331.20 2668.00 2126.R0

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Adult 3	112	1867115A	<input checked="" type="checkbox"/> Viral
2 Vanguard L4	189	A839157B	<input checked="" type="checkbox"/> Bacterial
3 Recombitek Lyme	298	42148	<input checked="" type="checkbox"/> Recombinant
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R Coxofemoral region	25	09/03/2009
2 1 ml	SQ	R Coxofemoral region	25	09/03/2009
3 1 ml	SQ	L Coxofemoral Region	25	09/03/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/03/2009
Concurrent Drugs or Procedures:	85 mg DIPHENHYDRAMINE IM

Event Information

* Event description: Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:

Dog examined and found to be apparently healthy. Pre-treated with 85mg (body weight) diphenhydramine Im which is s.o.p. Approximately 60 seconds after vaccination, dog vomited and collapsed. was obtunded with in 10 minutes. 20ga iv catheter installed and 0.9% NaCl administered @ 95ml/hr. 16mg dexamethasone sodium phosphate

administered IV and another 50mg diphenhydramine IV. Approximately 1 hour 15 minutes post reaction dog became responsive. within 2 hours standing in cage. 2 hours later vomiting/diarrhea blood - D.I.C. Dog transferred to emergency clinic and has been hospitalized/supported until 9/10/2009. Still serious condition, but stable.

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

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

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: Greater Swiss Mountain	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 3 yrs 11 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): No medical history, last vaccinated 2007, family pet		

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name	(b)(6)
Address: Rocky Shores Animal Hospital 341 Route 25a		Address	(b)(6)
City: Rocky Point		City	(b)(6)
State: NY		State: NY	
Zip: 11778		Zip	(b)(6)
*Phone: 631-209-2035(XXX-XXX-XXXX)		Phone	(b)(6) XXX-XXX-XXXX
FAX: 631 209-2417			
E-mail: rguasto@hotmail.com		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:	631-209-2035(XXX-XXX-XXXX)
*Today's Date:	09/10/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

[Submit](#)

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

Date Received: 09/10/2009

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: AIV10068

Product Code: 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 Duramune Max 5	112	916419A	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	LH hip	23	09/09/2009
2				
3				
4				

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

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Owner called approximately 10 mins after leaving stated patient was very lethargic and had vomited once upon getting home. Patient was examined at arrival & was given .05 ml Reglan SQ	

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: Pomeranian Chihuahua 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): 11 wks	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): patient presented with fleas, DHPP#1 given on 8/17/2009 & DHPP #2 given 9/9/2009	

Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: River City Animal Hospital 310 North Herborn Place		Address: (b)(6)	
City: Post Falls		City: (b)(6)	
State: ID		State: ID	
Zip: 83854		Zip: (b)(6)	
*Phone: 208-777-9178(XXX-XXX-XXXX)		Phone: (b)(6) XX-XXX-XXXX)	
FAX: 208-773-4558			
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:	208-777-9178(XXX-XXX-XXXX)
*Today's Date:	09/09/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 09/10/2009

Verified:yes

Reviewed:yes

Date Entered: 12/22/2009

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: AIV10065

Product Code: 1331.20 1905.20

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Adult 3	112	1867113A	<input checked="" type="checkbox"/> Viral
2 Imrab 3	298	12528A	<input checked="" type="checkbox"/> Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF	25	06/09/2009
2 1 ml	SQ	RH	25	06/09/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use: (MM/DD/YYYY)	06/09/2009
Concurrent Drugs or Procedures:	heartworm test

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Presented for mild facial (muzzle and periocular) edema. Treated with 18 mg benadryl IM. 30 mins later still had edema, so gavve 2 mg dex sp IV 30 mins later edema resolving.	

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 to 2 hrs
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):	Number affected:	1
Breed: Dachshund	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Male	Number dead:	0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): 1 year old ?? fine, got from breeder, no C/S/V/D. one cat in HH, 8/15/08, DHPP 1 yr, RV 1 yr.		

Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Jamaica Plain Animal Clinic 350 S. Huntington Avenue	Address:	(b)(6)
City:	Boston	City:	(b)(6)
State:	MA	State:	MA
Zip:	02130	Zip:	(b)(6)
*Phone:	617-522-7202(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:	617-522-7202(XXX-XXX-XXXX)
*Today's Date:	09/02/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 09/02/2009

Verified:yes

Reviewed:yes

Date Entered: 12/22/2009

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