

# 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: AIV09214

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	045144A	<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 F shoulder	22	04/02/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/02/2009
Concurrent Drugs or Procedures:	Physical Exam

Event Information

* Event description: <input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: Vomiting
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)	Approximately 12 hrs later	
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: Cockapoo	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): 4.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): WNL, healthy, no history of vaccine reactions. Has had the same Leptospirosis vaccine 1/17/07, 2/7/09, 2/1/08 with no known adverse events.		

### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: North Smithfield Animal Hospital 152 School St., P.O. Box 129		Address: (b)(6)	
City: Forestdale		City: (b)(6)	
State: RI		State: RI	
Zip: 02896		Zip: (b)(6)	
*Phone: 401-762-2400(XXX-XXX-XXXX)		Phone: (b)(6) XXX-XXX-XXXX	
FAX: 401-765-7679			
E-mail: (b)(6)@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:	04/07/2009(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: 04/07/2009

Verified:yes

Reviewed:yes

Date Entered: 06/15/2009

CVB Reporter:

Acknowledgement:

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

# 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: AIV09209

Product Code: 4637.29 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 Duramune Max 5/4L	112	BA350A222A	<input checked="" type="checkbox"/> Combination
2 Bronchi-Shield III	112	112429B	<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	L hip	25	04/03/2009
2 1 ml	Intranasal	Nares	N/A	04/03/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/03/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Shortly after vaccination, pt vomited profusely and defecated large amount. Gave 1.2 mg/lb Benadryl IM & monitored for 1 hr. Pt returned 2 hours after discharge with mild urticaria and mild hyperthermia (102.6f); gave 1 mg Dexamethasone IV. 1 hour later, urticaria almost entirely resolved, pt much brighter. Discharged at 3:15 PM.	

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): 15 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Previous vaccine 1 year ago DA2PP/C at Ft Carson Veterinary Clinic.		

**Personal Information**

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Beaverbrook Animal Hospital 1509 East Emory Road		Address: (b)(6)	
City: Knoxville		City: (b)(6)	
State: TN		State: TN	
Zip: 37938		Zip: (b)(6)	
*Phone: 865-688-2921(XXX-XXX-XXXX)		Phone: (b)(6) XXX-XXX-XXXX)	
FAX: 865-688-2963			
E-mail: BAHDVM@hotmail.com		E-mail: Unkown	

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:	865-688-2921(XXX-XXX-XXXX)

*Today's Date:	04/03/2009(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: 04/03/2009

Verified:yes

Reviewed:yes

Date Entered: 06/15/2009

CVB Reporter:

Acknowledgement:

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

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

Record Number: AIV09208

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	045148A	<input checked="" type="checkbox"/> Bacterial
2 Galaxy DA2PPvL	165A	212372A	<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	IS	25	03/31/2009
2 1 ml	SQ	IS	25	03/31/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/31/2009
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:  
 Dog has been vacc for DHPP and Lepto 5 at least 5 times in the past. This time, I gave her DHPP and 10 min later, gave her Lepto. 3 min later, she laid down and started salivating. This was immediately followed by anal sac expression, defecation and vomiting. Patient was in shock with tacky, muddy mucous membranes, tachypnea and

weak, nonpalpable pulses. Epinephrine, tripenillamine im and dexNaPO4 iv were given immediately. O2 via mask. IV catheter was set and LRS started at shock doses. No response. Repeated epi IV, dex IV. Took 2 hours to come around.

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

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

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1	
(Other Species):	Number affected: 1	
Breed: Labrador Retriever	Number vaccinated: 1	
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 4 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Healthy dog. Has had a few episodes of exercise induced collapse in her life. Has been vaccinated with DHLPP combo multiple times before by another veterinarian. No hx of problems.		

**Personal Information**

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Pet Hospital 2509 South 140 Circle		Address: (b)(6)	
City: Omaha		City: (b)(6)	
State: NE		State: NE	
Zip: 68144		Zip: (b)(6)	
*Phone: 402-330-3096(XXX-XXX-XXXX)		Phone: (b)(6) (XXX-XXX-XXXX)	
FAX: 402-330-9675			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Yes
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*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number:	402-330-3096(XXX-XXX-XXXX)
*Today's Date:	04/01/2009(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: 04/01/2009

Verified:yes

Reviewed:yes

Date Entered: 05/15/2009

CVB Reporter:

Acknowledgement:

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

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

Record Number: AIV09207

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	916359A	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ	Lumbar	25	01/23/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/23/2009
Concurrent Drugs or Procedures:	no

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: 4 mins after vax collapsed mucus membrane oxygen rescue. benedryl line deximeth. 20 mis later puppy OK 45 mins hives 60 mins later puppy went home	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	4 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: English Bulldog	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 - 5 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): puppy shots	

**Personal Information**

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Akron Animal Hospital 12638 Main Road, Rte 5		Address: (b)(6)	
City: Akron		City: (b)(6)	
State: NY		State: NY	
Zip: 14001		Zip: (b)(6)	
*Phone: 716-542-2208(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:	716-542-2208(XXX-XXX-XXXX)
*Today's Date:	04/01/2009(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: 04/01/2009

Verified:yes

Reviewed:yes

Date Entered: 05/15/2009

CVB Reporter: Page

Acknowledgement:

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# 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: AIV09206

Product Code: 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 Duramune Max 5	112	916341A	<input checked="" type="checkbox"/> Viral
2 Intra-Trac III	165A	54189B	<input checked="" type="checkbox"/> Combination
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	22	03/31/2009
2 1 ml	Intranasal	nasal		03/31/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/31/2009
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: dog presented about 1 hour after vaccination with facial edema, urticaria along trunk, panting & sever pruritis. symptoms resolved within 1 hour of administration of diphenhydramine IM & dexamethasone (low dose) 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)	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: Shih Tzu/Mini poodle	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.): unsure of acquisition. has been vaccinated yearly before with no events. history of cystotomy for bladder stones, w/d food. housed indoors as sole pet.	

### Personal Information

Veterinarian	Owner
*Name: (b)(6)	Name: (b)(6)
Address: Ames Pet Hospital 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:	04/01/2009(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: 04/01/2009

Verified:yes

Reviewed:yes

Date Entered: 05/15/2009

CVB Reporter:

Acknowledgement: yes

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

Record Number: AIV09205

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	916346A	<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	L shoulder	25	03/11/2009
2				
3				
4				

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

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Dog developed lip swelling 4 hrs post. Vaccine give at 10 am following a pre-med of Benedryl inj at 9 am. Dog had vaccine reaction 8-31-07.	

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:	b249-2	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Chihuahua	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	12 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): routine			

#### Personal Information

Veterinarian		Owner	
*Name:	[REDACTED]	Name:	
Address:	Tates Creek Animal Hospital 4101 Tates Creek Center Drive, Ste 146	Address:	
City:	Lexington	City:	
State:	KY	State:	
Zip:	40517	Zip:	
*Phone:	859-273-1933(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	859-273-1974		
E-mail:	tatescreekanimal@yahoo.com	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	[REDACTED] (b)(6)
*Submitter's Last Name:	[REDACTED] (b)(6)
*Submitter's Phone Number:	859-273-1974(XXX-XXX-XXXX)
*Today's Date:	03/11/2009(MM/DD/YYYY)

Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	Vet tech at practice and owner of this pet

Submit

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

Date Received: 03/11/2009

Verified:yes

Reviewed:yes

Date Entered: 05/15/2009

CVB Reporter:

Acknowledgement:

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

Record Number: AIV09202

Product Code: 13D1.29 14P5.20 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Duramune Max 5	112	916357A	<input checked="" type="checkbox"/> Viral
2 Duramune Cv-k	112	145262A	<input checked="" type="checkbox"/> Viral
3 Imrab 1 TF	298	22017B	<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 hip	23	03/25/2009
2 1 ml	SQ	R hip	23	03/25/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/25/2009
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 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)	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:	8984	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Shiba Inu	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> 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:	651-690-9898		
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	
*Submitter's Last Name	
*Submitter's Phone Number:	651-690-1564(XXX-XXX-XXXX)
*Today's Date:	03/30/2009(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: 03/30/2009

Verified: yes

Reviewed: yes

Date Entered: 05/15/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. [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: AIV09200

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	1867111A	<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	LF shoulder	25	03/20/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/20/2009
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: 1 episode of vomiting food, hives, facial swelling and edema for about 8 hours. Given 10 mg benadryl liquid and 2.5 mg prednisone in a 10# dog	

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:	Jillian Haynes	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 Pinscher	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):	5.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Only has had rabies (1 & 3yr), and duramune Max 5. In a day care environment and well controlled outside access			

#### Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	Fairland Animal Hospital 12711 Old Columbia Pike	Address	(b)(6)
City:	Silver Spring	City:	
State:	MD	State:	
Zip:	20904	Zip:	
*Phone:	301-622-2115(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	301-622-2979		
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:	310-622-2115(XXX-XXX-XXXX)
*Today's Date:	03/26/2009(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: 03/26/2009

Verified:yes

Reviewed:yes

Date Entered: 05/15/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. [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: AIV09199

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 Imrab 3 TF	298	18086A	<input checked="" type="checkbox"/> Viral
2 Duramune Adult 3	112	1867111A	<input checked="" type="checkbox"/> Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RH leg	25	
2 1 ml	SQ	R shoulder	25	03/09/2009
3				
4				

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

Event Information

* Event description: <input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: local vaccine 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)	48 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:	in treatment with Rimadyl

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

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	Frontier Veterinary Hospital 4500 NE Cornell Road	Address:	
City:	Hillsboro	City:	
State:	OR	State:	
Zip:	97124	Zip:	
*Phone:	503-648-1643(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:	503-648-1643(XXX-XXX-XXXX)
*Today's Date:	03/26/2009(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: 03/26/2009

Verified: yes

Reviewed: yes

Date Entered: 05/15/2009

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. <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: AIV09198

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	350251A	<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 hip	22	03/17/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/17/2009
Concurrent Drugs or Procedures:	Benadry IM / Dex SP SC

Event Information

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

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

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

### Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Golden Retriever	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Not Listed	
Age (i.e., 2 yrs or 2 mos): 19 mos	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):	

### Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	Hardin Valley Animal Hospital 10017 Hardin Valley Road	Address:	
City:	Knoxville	City:	
State:	TN	State:	
Zip:	37932	Zip:	
*Phone:	865-539-6811(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:	865-539-6811(XXX-XXX-XXXX)
*Today's Date:	03/26/2009(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: 03/27/2009

Verified:yes

Reviewed:yes

Date Entered: 05/15/2009

CVB Reporter:

Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. [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: AIV09197

Product Code: 2668.05 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 LCI-GP	112	045144A	<input checked="" type="checkbox"/> Bacterial
2 Intra-Trac II	165A	53657B	<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	Prescapular	22	03/19/2009
2 1 ml	IN			03/19/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/19/2009
Concurrent Drugs or Procedures:	Venipuncture for Heartworm Test

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Within 2 hours of receiving vaccines - developed angioneurotic edema in the face. Presented to the emergency clinic where he received IV Dexamethasone and Benadryl. Responded completely to 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)	1-2 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:	2009US01552	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	English Setter	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 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Owner acquired the dog from the breeder a few weeks prior to presenting for vaccinations. He had been previously vaccinated for DHPP but product information was unknown.			

**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:	952-848-0896		
E-mail:	drkerrieb@allpawsvets.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:	952-848-0913(XXX-XXX-XXXX)

*Today's Date:	03/25/2009(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: 03/25/2009

Verified:yes

Reviewed:yes

Date Entered: 05/15/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09196

Product Code: 2668.05 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 LCI-GP	112	045144A	<input checked="" type="checkbox"/> Bacterial
2 Intra-Trac II	165A	53655A	<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	Intrascapular	22	02/18/2009
2 1 ml	IN			02/18/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/18/2009
Concurrent Drugs or Procedures:	None

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Received vaccinations. About 1 hour later developed facial edema and mild diffuse hives. Presented to the emergency clinic at the veterinary teaching hospital. Here she received an injection of a steroid (do not know which one) and diphenhydramine (dose and route of administration unknown). Fully recovered within 24 hours.	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	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:	2009US01551	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Pug	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	2.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Personal pet. Acquired as puppy. Had previous DHPP, Rabies, Bordetella previously, but had never had leptospirosis before.			

#### 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:	MINN
Zip:	55416	Zip:	(b)(6)
*Phone:	952-848-0913(XXX-XXX-XXXX)	Phone:	(b)(6) (XXX-XXX-XXXX)
FAX:	952-848-0896		
E-mail:	(b)(6)@allpawsvets.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:	952-848-0913(XXX-XXX-XXXX)

*Today's Date:	03/25/2009(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: 03/25/2009

Verified:yes

Reviewed:yes

Date Entered: 05/15/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09195

Product Code: 12X1.20 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 Bronchi-Shield 3	112	112429C	<input checked="" type="checkbox"/> Combination
2 Duramune Max 5	112	916346A	<input checked="" type="checkbox"/> Viral
3 Rabvac 3 TF	112	873173A	<input checked="" type="checkbox"/> Viral
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	IN	Nose	n/a	03/14/2009
2 1 ml	SQ	Lhip	25	03/14/2009
3 1 ml	SQ	Rhip	25	03/14/2009
4				

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

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: Snout of dog swelled up, per owner it is due to the bordetella 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)	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:	owner gave benadryl @ home

**Animal Information**

Case Identification:	4242	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Pug	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	10 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Tates Creek Animal Hospital 4101 Tates Creek Center, Ste. 146	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"/> No
*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:	03/25/2009(MM/DD/YYYY)
Relationship to animal:	

<input checked="" type="checkbox"/> Veterinarian
Other: Call tech with any questions

Submit

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

Date Received: 03/25/2009

Verified: yes

Reviewed: yes

Date Entered: 05/15/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09191

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	916347A	<input checked="" type="checkbox"/> Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L shoulder	25	01/13/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/13/2009
Concurrent Drugs or Procedures:	Benadryl 3.0 mg SQ

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Probable Type 1 hypersensitivity - collapse, pallor, tachycardia within 4 minutes of DHPP.	
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 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: Shih-Tzu	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): 11 wks	
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: Pleasant Valley Veterinary Center 10171 Commercial Avenue	Address (b)(6)
City: Penn Valley	City (b)(6)
State: CA	State: CA
Zip: 95946	Zip (b)(6)
*Phone: 530-432-8443(XXX-XXX-XXXX)	Phone (b)(6) XXX-XXX-XXXX
FAX: 530-432-8673	
E-mail: (b)(6)@pennvalleyvet.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:	530-432-8443(XXX-XXX-XXXX)
*Today's Date:	03/19/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 03/19/2009

Verified:yes

Reviewed:yes

Date Entered: 05/12/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09188

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	916384A	<input checked="" type="checkbox"/> Combination
2 LCI-GP	112	350253A	<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	25	03/12/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/12/2009
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: Within 3 minutes of giving the vaccine, puppy became agitated, walked in a circle then layed down. He quickly became pale and lost consciousness. Treatment included Oxygen by mask, IV fluids (5% dex in 0.9 % NaCL), 0.3cc dexamethazone 2mg/ml IV, 0.14 cc diphenhydramine 50 mg/ml. Puppy regained consciousness and returned to	

normal mucous membrane color within 5 minutes.	
If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Other
Other:	

**Animal Information**

Case Identification:	Milo Posteraro	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	West Highland Terrier	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):	3 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Bought from breeder 2-13-09 received vaccines starting at 3 weeks up to 8 weeks (no leptospirosis) at breeder. Lives in house, no other animals. First dog for this family. No children.			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Animal Hospital of Chester County 1353 Pottstown Pike	Address:	(b)(6)
City:	West Chester	City:	(b)(6)
State:	PA	State:	PA
Zip:	19380	Zip:	(b)(6)
*Phone:	610-692-7560(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX
FAX:	610-692-7561		
E-mail:	ahcc1353@aol.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:	610-692-7560(XXX-XXX-XXXX)
*Today's Date:	03/17/2009(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: 03/17/2009

Verified:yes

Reviewed:yes

Date Entered: 05/12/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09187

Product Code: 1905.23 13D1.29 2668.05 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 Imrab 3 TF	298	18086C	<input checked="" type="checkbox"/> Viral
2 Duramune Max 5	112	916364A	<input checked="" type="checkbox"/> Viral
3 LCI-GP	112	350252A	<input checked="" type="checkbox"/> Bacterial
4 Naramune-2	124	104591	<input checked="" type="checkbox"/> Combination

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip	25	03/06/2009
2 1 ml	SQ	R scapula	25	03/06/2009
3 1 ml	SQ	R scapula	25	03/06/2009
4 1 ml	IN	N/A	N/A	03/06/2009

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/06/2009
Concurrent Drugs or Procedures:	

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: 30 min: facial edema, vomiting, pale mm, elevated temp; 24 hr: limping R forelimb	
If this adverse event involves a possible lack of efficacy with a rabies product please	

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

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

**Animal Information**

Case Identification:	Fort Dodge: 2009-US-01284; MER: 09-13248; BI: 2009-US-1330	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Labrador Retriever	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs 5 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): healthy			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Triangle Veterinary Hospital, Inc. 3301 Old Chapel Hill Road	Address:	(b)(6)
City:	Durham	City:	(b)(6)
State:	NC	State:	NC
Zip:	27707	Zip:	27707
*Phone:	919-489-2391(XXX-XXX-XXXX)	Phone:	919-489-6201(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:	919-489-2391(XXX-XXX-XXXX)

*Today's Date:	03/13/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Other
Other:	Veterinarian administrative assistant

Submit

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

Date Received: 03/13/2009

Verified:yes

Reviewed:yes

Date Entered: 05/12/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09186

Product Code: 2100.02 13D1.29 1905.23 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 Bronchicine CAe	189	A832120B	<input checked="" type="checkbox"/> Bacterial
2 Duramune Max 5	112	916349A	<input checked="" type="checkbox"/> Viral
3 Imrab 3 TF	298	18084C	<input checked="" type="checkbox"/> Viral
4 CvK/LCI-GP	112	094222A	<input checked="" type="checkbox"/> Combination

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Upper right hip	22	11/01/2009
2 1 ml	SQ	L hip	22	03/10/2009
3 1 ml	SQ	Lower right hip	22	11/01/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/10/2009
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: Vomiting 6 times over a 2 hr period. Restless, pruritic, painful palpation of left hip.
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:	"Kiwi"	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Maltese	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	2.5 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) 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:	03/11/2009(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: 03/11/2009

Verified:yes

Reviewed:yes

Date Entered: 05/12/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09185

Product Code: 16D1.22 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 Fel-O-Guard Plus 3	112	117175A	<input checked="" type="checkbox"/> Viral
2 Imrab 3 TF	298	18088C	<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 shoulder	23	03/07/2009
2 1 ml	SQ	R hip	23	03/07/2009
3				
4				

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

Event Information

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

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	5 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

#### Animal Information

Case Identification:	8819	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	DSH	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	2 yrs		
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:	03/11/2009(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: 03/11/2009

Verified:yes

Reviewed:yes

Date Entered: 05/12/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09183

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	916337A	<input checked="" type="checkbox"/> Viral
2 LCI-GP	112	350248A	<input checked="" type="checkbox"/> Bacterial
3			
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L shoulder	25	02/27/2009
2 1 ml	SQ	L shoulder	25	02/27/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/27/2009
Concurrent Drugs or Procedures:	dental cleaning done; see form for drugs.

## Event Information

* Event description: <input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: when dog got home lethargic, painful, vomiting & loose stool.

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"/> Medium
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

### Animal Information

Case Identification:	4641	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Pomeranian	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	2 yrs 3 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): overdue for vaccines, currently acquired, living with cats.			

### 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:	03/10/2009(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: 03/10/2009

Verified:yes

Reviewed:yes

Date Entered: 05/12/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09182

Product Code: 14P5.20 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 CV	189	A831851A	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A831191	<input checked="" type="checkbox"/> Viral
3			
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml		back of neck		
2 1 ml		back of neck		
3				
4				

Administered by:	<input checked="" type="checkbox"/> Non-veterinarian
*Date of Product Use:(MM/DD/YYYY)	02/22/2009
Concurrent Drugs or Procedures:	none

**Event Information**

\* Event description:  Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:  
 gave 4 pups (9 wks) booster, 1 dose each pup. 30 mins after injection, lips, eyes, throat, ears swelled. Gave 25 mg benadryl & on vets advice gave 25 mg liquied 30 mins later. 3.5 hrs later the swelling down significantly. (only occured in 1 pup, other 3 fine. I have had other dogs (golden retrievers) with similar reactions when given 12 week

shots.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30 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:4
(Other Species):	Number affected:1
Breed :Golden Retriever	Number vaccinated:4
Sex: <input checked="" type="checkbox"/> Male	Number dead:0
Neutered: <input checked="" type="checkbox"/> Not Listed	
Age (i.e., 2 yrs or 2 mos):9 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:	Address:
City: Fort Scott	City:
State: KS	State:
Zip:66701	Zip:
*Phone:515-232-5785(XXX-XXX-XXXX)	Phone (b)(6) (XX-XXX-XXXX)
FAX:	
E-mail:	E-mail:

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

*Today's Date:	02/22/2009(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: 04/06/2009

Verified:yes

Reviewed:yes

Date Entered: 05/12/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09180

Product Code: 13D1.20 1905.23 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 Galaxy DA2PPvL	165A	not given	<input checked="" type="checkbox"/> Viral
2 Rabvac 3 TF	112	not given	<input checked="" type="checkbox"/> Viral
3 Intra-Trac 3	165A	not given	<input checked="" type="checkbox"/> Combination
4			

Administration of products.

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

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/03/2009
Concurrent Drugs or Procedures:	Rabvac 3 TF - est. 112; Intra-Trac 3 - Est. 165A

Event Information

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

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

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

### Animal Information

Case Identification:	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: Airedale	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.):	

### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Three Oaks Veterinary Service 7059 Broad Street		Address:	
City: Brooksville		City:	
State: FL		State:	
Zip: (b)(6)		Zip:	
*Phone: (b)(6) (XXX-XXX-XXXX)		Phone: (XXX-XXX-XXXX)	
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> Not Listed
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	352-797-7777(XXX-XXX-XXXX)
*Today's Date:	02/04/2009(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: 04/06/2009

Verified:yes

Reviewed:yes

Date Entered: 05/12/2009

CVB Reporter:

Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB website. [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: AIV09178

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	1867110A	<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 area	22	03/06/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/06/2009
Concurrent Drugs or Procedures:	physical exam

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Gave vaccine, dog began to vomit within 10 minutes in exam room, collapsed, cyanotic, thready pulse. Gave epinephrine -IV, Dex SP-IV, diphenhydramine -IM, LRS/Hetastarch IV, O2 by facemask, Famotidine 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:	Misty Thomas	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"/> 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.): Very well cared for, on Hill's ZD diet due to food allergy, also flea allergic, also has atopy, on Interceptor			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Countryside Animal Clinic 225 West 4th Avenue	Address:	(b)(6)
City:	Junction City	City:	(b)(6)
State:	OR	State:	OR
Zip:	97448	Zip:	(b)(6)
*Phone:	541-998-6036(XXX-XXX-XXXX)	Phone:	(b)(6) (XXX-XXX-XXXX)
FAX:	541-998-4683		
E-mail:	(b)(6)@aol.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:	541-998-6036(XXX-XXX-XXXX)
*Today's Date:	03/09/2009(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: 03/09/2009

Verified:yes

Reviewed:yes

Date Entered: 04/21/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09173

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	045146A	<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	Intrascapular	22	02/10/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/10/2009
Concurrent Drugs or Procedures:	No other vaccines given. Blood was taken for a profile and HWT

Event Information

* Event description:	<input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: Beginning 4-5 days post vaccine - owner noticed a local swelling that continued to grow for 4-5 days. It reached the size of a golf ball. Treatment consisted of warm packing the affected site twice a day. Two weeks after the vaccine	

the lump is about 2cm in diameter and 3-4 mm thick.

<p>If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.</p>	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	4 days
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered without treatment
Other:	

### Animal Information

Case Identification:	2009-US-01039	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):	3 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Had a previous leptospirosis vaccine w/o incident on 12/12/2007			

### 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:	952-848-9896		
E-mail:	(b)(6)@allpawsvets.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)
	952-848-0913(XXX-XXX-XXXX)

*Submitter's Phone Number:	
*Today's Date:	03/02/2009(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: 03/02/2009

Verified:yes

Reviewed:yes

Date Entered: 04/21/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09172

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	916378A	<input checked="" type="checkbox"/> Viral
2 Rabvac 3 TF	112	873171A	<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	25	03/02/2009
2 1 ml	SQ	R shoulder	25	03/02/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/02/2009
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.	
ROC: 1APR09, I contacted clinic and gathered this event description.	

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:	5470-1	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Chihuahua	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	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:	Tates Creek Animal Hospital 4101 Tates Creek Center Drive #146	Address	(b)(6)
City:	Lexington	City	(b)(6)
State:	KY	State:	KY
Zip:	40517	Zip	(b)(6)
*Phone:	859-273-1933(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX
FAX:			
E-mail:		E-mail	(b)(6)

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*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:	03/02/2009(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: 03/02/2009

Verified:yes

Reviewed:yes

Date Entered: 04/21/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09166

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	1867111A	<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 region	23	02/26/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/26/2009
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: Snickers presented for a DA2PP vaccination and heartworm test. The injection was given (appointment was in late afternoon). We recieved a report from the local emergency clinic 2/27/09. Snickers presented there 2 hours after vaccination for facial swelling, erythema and pruritus. She was treated with Diphenhydramine and Dexamethasone	

SP and released.

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) (Other Species):	Number in group: 1
Breed: Yorkipoo	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): 5 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Probable food allergic	

### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Token Creek Veterinary Clinic 3790 State Road 19		Address: (b)(6)	
City: Sun Prairie		City: (b)(6)	
State: WI		State: WI	
Zip: 53590		Zip: (b)(6)	
*Phone: 608-834-9700(XXX-XXX-XXXX)		Phone: (XXX-XXX-XXXX)	
FAX: 608-834-0700			
E-mail: (b)(6)@tokencreekvet.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)
	608-834-9700(XXX-XXX-XXXX)

*Submitter's Phone Number:	
*Today's Date:	02/27/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 02/27/2009

Verified:yes

Reviewed:yes

Date Entered: 04/21/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09164

Product Code: 1905.23 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 Imrab 3 TF	298	18000B	<input checked="" type="checkbox"/> Viral
2 Recombitek Lyme	298	42138	<input checked="" type="checkbox"/> Recombinant
3 Duramune Max 5	112	916365A	<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 shoulder	25	02/26/2009
2 1 ml	SQ	Between shoulders	25	02/26/2009
3 1 ml	SQ	L shoulders	25	02/26/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/26/2009
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 redness
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 to 3 hrs	
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> Not Listed	
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment	
Other:		

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):	Number affected:	1
Breed : Chihuahua	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Female	Number dead:	0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1yrs 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: Apple Valley Animal Hospital 1207 Cedar Creek Grade		Address:	
City: Winchester		City:	
State: VA		State:	
Zip: 22602		Zip:	
*Phone: 540-678-0202(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:	540-678-0202(XXX-XXX-XXXX)
*Today's Date:	02/27/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 02/27/2009

Verified:yes

Reviewed:yes

Date Entered: 04/20/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09162

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	916345A	<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	02/24/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/24/2009
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	<input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: vomiting/diarrhea 24 hours after administration	
If this adverse event involves a possible lack of efficacy with a rabies product please	

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

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

### 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"/> 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.):		

### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name:	
Address: Atlantic Animal Clinic 35 NE 25th Avenue		Address:	
City: Boca Raton		City:	
State: FL		State:	
Zip: 33431		Zip:	
*Phone: 954-942-3323(XXX-XXX-XXXX)		Phone: (XXX-XXX-XXXX)	
FAX: 954-942-3971			
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:	954-942-3323(XXX-XXX-XXXX)
*Today's Date:	02/26/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 02/26/2009

Verified:yes

Reviewed:yes

Date Entered: 04/20/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09155

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	916330A	<input checked="" type="checkbox"/> Viral
2 LeptoVax 4	112	350247A	<input checked="" type="checkbox"/> Bacterial
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	25	02/12/2009
2 1 ml	SQ	R shoulder	25	02/12/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/12/2009
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: about 2 hours after receiving vaccine; dog pruritic, urticaria, erythema. received diphenhydramine 12 mg/SQ & dex SP 1.36 mg 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)	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:	8424	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Yorkie	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): owner recently acquired dog. has had these vaccines in the past with no problems. no health problems. eats natural balance dog food.			

**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:	02/13/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 02/13/2009

Verified:yes

Reviewed:yes

Date Entered: 04/20/2009

CVB Reporter: Osorio

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09154

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	916347A	<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	25	02/09/2009
2				
3				
4				

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

Event Information

* Event description: <input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Moderate facial swelling, treated with diphenhydramine 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)	< 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:	Higgins	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"/> 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.): Acquired 1 month ago, DHPP given by breeder on 1/9/09, also came in with diarrhea, otherwise healthy puppy eating lams.			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Interbay Veterinary Care Center 3040 16th Ave W	Address:	(b)(6)
City:	Seattle	City:	(b)(6)
State:	WA	State:	WA
Zip:	98119	Zip:	(b)(6)
*Phone:	206-282-1961(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	206-282-1962		
E-mail:	interbay@comcast.net	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	(b)(6)
*Submitter's Phone Number:	206-282-1961(XXX-XXX-XXXX)
*Today's Date:	02/11/2009(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: 02/12/2009

Verified:yes

Reviewed:yes

Date Entered: 04/20/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09153

Product Code: 12X1.20 13D1.29 1905.21

\* 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 BronchiShield III	112	112416B	<input checked="" type="checkbox"/> Combination
2 Duramune Max 5	112	916347A	<input checked="" type="checkbox"/> Viral
3 Rabvac 3 TF	112	1215341B	<input checked="" type="checkbox"/> Viral
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	IN	nasal		01/10/2009
2 1 ml	SQ	R shoulder blade	25	01/10/2009
3 1 ml	SQ	L shoulder blade	25	01/10/2009
4				

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

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: patient left vaccination clinic. owner contacts us about patients lethargy & possilbe resp distress. our facility directs owner to take patient to his vet clinic immediately. patient treated/stablized at Poste Veterinary Hospital with transfer to UCAC for overnight monitoring. patient appeared to be doing well but crashed & died.	

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"/> Died
Other:	

### Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Pug X	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): 2 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): patient seen at vaccination clinic - PE WNL for breed/age. due to patient status as "rescued" medical history unknown.	

### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Silicon Valley Animal Control Authority 3370 Thomas Road		Address: (b)(6)	
City: Santa Clara		City: (b)(6)	
State: CA		State: CA	
Zip: 95054		Zip: (b)(6)	
*Phone: 408-764-0344(XXX-XXX-XXXX)		Phone: (b)(6) XXX-XXX-XXXX	
FAX: 408-788-5411			
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:	408-764-0658(XXX-XXX-XXXX)

*Today's Date:	02/10/2009(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: 02/10/2009

Verified:yes

Reviewed:yes

Date Entered: 04/20/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09150

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	A830081A	<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 F shoulder		02/09/2009
2				
3				
4				

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

Event Information

* Event description: <input checked="" type="checkbox"/> Local
Explain the event and any treatment in a concise paragraph: Patient was very painful at vaccine site directly after giving 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)	immediately
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: Bernese Mountain Dog	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): 12 wks		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):		

**Personal Information**

Veterinarian		Owner	
*Name: (b)(6)		Name:	
Address: McKenzie Animal Hospital 5303 Main Street		Address:	
City: Springfield		City:	
State: OR		State:	
Zip: 97478		Zip:	
*Phone: 541-747-3859(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:	541-747-3859(XXX-XXX-XXXX)
*Today's Date:	02/09/2009(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: 02/10/2009

Verified:yes

Reviewed:yes

Date Entered: 04/20/2009

CVB Reporter:

Acknowledgement:

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# Adverse Event Report

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

Record Number: AIV09147

Product Code: 13D1.29 46E5.21 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 Max 5	112	916345A	<input checked="" type="checkbox"/> Viral
2 CvK/LCI-GP	112	094227A	<input checked="" type="checkbox"/> Combination
3 Rabvac 1	112	1213177A	<input checked="" type="checkbox"/> Viral
4			

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R front shoulder	22	02/02/2009
2 1 ml	SQ	R rear hip	22	02/02/2009
3				
4				

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

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: moderate facial swelling & hives over back. diphenhydramine (0.2 ml) IM, dexamethasone-SP (0.16 ml) IM SQ fluids 100 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)	7 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: Toy Fox Terrier	Number vaccinated:	1
Sex: <input checked="" type="checkbox"/> Male	Number dead:	0
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): unknown - new dog		

#### 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:	02/06/2009(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: 02/09/2009

Verified:yes

Reviewed:yes

Date Entered: 04/10/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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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: AIV09144

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

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S831726A	<input checked="" type="checkbox"/> Viral
2 Vanguard Plus 5	189	A831191	<input checked="" type="checkbox"/> Viral
3 Vanguard CV	189	A831851A	<input checked="" type="checkbox"/> Viral
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	23	02/04/2009
2 1 ml	SQ	Intrascapular	23	02/04/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/04/2009
Concurrent Drugs or Procedures:	None

**Event Information**

* Event description: <input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: One episode of vomit and pale gums 30 minutes after administration. Hives about 3 hours after administration.
If this adverse event involves a possible lack of efficacy with a rabies product please

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

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

**Animal Information**

Case Identification:	Glen	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Pug	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos):	1.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Had 3 DHPPC as a puppy and 1 year Rabies on 1.25.08			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	All West Veterinary Hospital 105 All West Trail	Address	(b)(6)
City:	Bozeman	City	(b)(6)
State:	MT	State:	MT
Zip:	59718	Zip	(b)(6)
*Phone:	406-586-4919(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:	(b)(6)@bresnan.net	E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number:	406-586-4919(XXX-XXX-XXXX)
*Today's Date:	02/05/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 02/05/2009

Verified:yes

Reviewed:yes

Date Entered: 04/10/2009

CVB Reporter:

Acknowledgement:

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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: AIV09142

Product Code: 2100.02 1905.23 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 Bronchicine CAe	189	A831582	<input checked="" type="checkbox"/> Bacterial
2 Imrab 3 TF	298	18088A	<input checked="" type="checkbox"/> Viral
3 Duramune LCI/GP	112	350247A	<input checked="" type="checkbox"/> Bacterial
4			

**Administration of products.**

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

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/31/2009
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: 3 hrs post vaccine presented to ER with facial swelling & urticaria. given dex sp IV diphenhydramine 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:	0149	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"/> No		
Age (i.e., 2 yrs or 2 mos):	2.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): had since puppy. no health problems. one other dog in household. eats royal canine. received these vaccines in past with no problems.			

**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:	02/05/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 02/05/2009

Verified:yes

Reviewed:yes

Date Entered: 04/10/2009

CVB Reporter:

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

# Adverse Event Report

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

Record Number: AIV09141

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	A831582	<input checked="" type="checkbox"/> Bacterial
2 Imrab 3 TF	298	18088A	<input checked="" type="checkbox"/> Viral
3 Duramune Max 5	112	916330A	<input checked="" type="checkbox"/> Viral
4			

## Administration of products.

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

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/31/2009
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: in for routine exam & vaccines. received vaccines in past with no problems. about 3 hours post vaccines presented at ER with facial swelling & urticaria. give diphenhydramine IM & 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)	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:	0149	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):	2.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): had since puppy. no health problems. one other dog in household. eats royal canine.			

#### 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:	02/05/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 02/05/2009

Verified:yes

Reviewed:yes

Date Entered: 04/10/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09140

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		<input checked="" type="checkbox"/> Viral
2 Imrab 3 TF	298		<input checked="" type="checkbox"/> Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L shoulder	22	
2 1 ml	SQ	R shoulder	22	
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/05/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description: <input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: hives outside rear leg, facial swelling, all 4 limbs swollen
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: Puggle	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 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: Apple Valley Animal Hospital 1207 Cedar Creek Grade		Address:	
City: Winchester		City:	
State: VA		State:	
Zip: 22602		Zip:	
*Phone: 540-678-0202(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:	540-678-0202(XXX-XXX-XXXX)
*Today's Date:	02/05/2009(MM/DD/YYYY)
Relationship to animal:	

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

Submit

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

Date Received: 02/05/2009

Verified:yes

Reviewed:yes

Date Entered: 04/10/2009

CVB Reporter: Schierer/Walker

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09137

Product Code: 1331.20 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 Adult 3	112	1867107A	<input checked="" type="checkbox"/> Viral
2 LeptoVax 4	112	045144A	<input checked="" type="checkbox"/> Bacterial
3 Bronchicine CAe	189	A831582	<input checked="" type="checkbox"/> Bacterial
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip	22	01/31/2009
2 1 ml	SQ	Upper R hip	22	
3 1 ml	SQ	L hip	22	
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/31/2009
Concurrent Drugs or Procedures:	ear cleaning several hours later @ home

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Blue had vaccines late morning. That evening the owners cleaned her ears with an ear cleaning solution and noticed facial swelling & started rubbing her face. She vomited 3 times & went to the emergency clinic. 70 mg benadryl IM,	

3.2 mg Dex SP IM, 9.5 mg Reg/an SQ.

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

**Animal Information**

Case Identification:	Blue	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"/> Yes		
Age (i.e., 2 yrs or 2 mos):	9 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): vaccinations			

**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)
	614-276-5479(XXX-XXX-XXXX)

*Submitter's Phone Number:	
*Today's Date:	02/03/2009(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: 02/03/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09133

Product Code: 13D1.29 47E5.21

\* 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		<input checked="" type="checkbox"/> Viral
2 LeptoVax 4/C + LymeVax	112		<input checked="" type="checkbox"/> Combination
3			
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	LH	23	01/29/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/29/2009
Concurrent Drugs or Procedures:	physical exam & advantix

**Event Information**

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

Explain the event and any treatment in a concise paragraph:  
 the puppy came in for puppy vaccines and exam, physical exam was normal. received duramune max 5-CvK/4L at 2:15 p.m. when owner was leaving puppy vomited most likely from excitement of day. we decided to keep puppy for a couple hours for observation. 3.5 hours later we noticed facial swelling and lethargy from puppy. administered 0.33

ml diphenhydramine and continued observation.

<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)	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) (Other Species):	Number in group: 1
Breed: Labrador Retriever	Number affected: 1
Sex: <input checked="" type="checkbox"/> Male	Number vaccinated: 1
Neutered: <input checked="" type="checkbox"/> No	Number dead: 0
Age (i.e., 2 yrs or 2 mos): 9 wks	

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):  
 owner acquired puppy from a friend who had the litter. as of 1/29/09 owner had puppy for 4 weeks. puppy received 6 week booster at breeder and was returning 01/29/09 for 9 week booster. puppy eats puppy chow by purina for 4 weeks. aside from owner reporting flatulence puppy has been healthy. on the morning of 1/29/09 owner did report the puppy had diarrhea and explained he bought new treats and puppy received a good amount that morning.

**Personal Information**

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: All Pets Hospital 9308 Perkins Road		Address: (b)(6)	
City: Baton Rouge		City: (b)(6)	
State: LA		State: LA	
Zip: 70810		Zip: (b)(6)	
*Phone: 225-797-2462(XXX-XXX-XXXX)		Phone: (b)(6) XXX-XXX-XXXX	
FAX: 225-767-2994			
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:	225-767-2462(XXX-XXX-XXXX)
*Today's Date:	01/30/2009(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: 01/30/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09132

Product Code: 13D1.22 14P5.20 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 Vanguard Plus 5	189	A826189A	<input checked="" type="checkbox"/> Viral
2 Vanguard CV	189	A725753B	<input checked="" type="checkbox"/> Viral
3 Naramune-2	124	552	<input checked="" type="checkbox"/> Combination
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF	25	01/23/2009
2				
3 .5 ml	Nasal	intranasal		01/23/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/23/2009
Concurrent Drugs or Procedures:	PE, .35 cc strongid p.o.

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: within 15 mins of vaccines, dog went pale, limp & vomited. Tx'd with iv fluids, epinephrine, dexamethasone, benadryl; lungs became congested - give lasix & O2; external heat source - hypothermic.	

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

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

### Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)	
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1	
(Other Species):	Number affected: 1	
Breed: 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): 12 wks		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): home environment, good health, owner has had 1.5 mos.		

### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Berkley Animal Clinic 3996 West 12 Mile Road		Address: (b)(6)	
City: Berkley		City: (b)(6)	
State: MI		State: MI	
Zip: 48072		Zip: (b)(6)	
*Phone: 248-545-4933(XXX-XXX-XXXX)		Phone: (b)(6) XXX-XXX-XXXX)	
FAX: 248-545-8908			
E-mail: berkleyanimalclinic.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:	248-545-4933(XXX-XXX-XXXX)
*Today's Date:	01/28/2009(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: 01/30/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09131

Product Code: 2100.02 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 Bronchicine CAe	189	A832120B	<input checked="" type="checkbox"/> Bacterial
2 Vanguard Plus 5 L4	189	A832328A	<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	L thigh	25	01/14/2009
2 1 ml	SQ	R shoulder	25	01/14/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	1/14/2009
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 less than 15 minutes from administration of immunizations, re-presented with generalized, severe urticaria, angioedema, vomiting, tachycardia, and hypovolemic shock, with pulses barely palpable. Treatment with epiheprine and diphenhydramine resulted in improvement in signs, with ongoing vomiting that responded to famotidine (given

approximately 25 minutes after presentation. Ongoing care at ER facility consisted of IV fluid therapy and continuation of diphenhydramine.

<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:	Lucky Ciccarello	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Mini dachshund	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Male	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos):	3 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Previously vaccinated at pet store from which acquired			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	
Address:	VCA Oldsmar Animal Hospital 3898 Tampa Road	Address:	
City:	Oldsmar	City:	
State:	FL	State:	
Zip:	34677	Zip:	
*Phone:	813-855-4669(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	813-855-2360		
E-mail:	(b)(6)@vcamail.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:	813-855-4699(XXX-XXX-XXXX)
*Today's Date:	01/27/2009(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: 01/27/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09127

Product Code: 2668.05 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 LCI-GP	112	045143A	<input checked="" type="checkbox"/> Bacterial
2 Recombitek Lyme	298	42141	<input checked="" type="checkbox"/> Recombinant
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	LF	25	01/13/2009
2 1 ml	SQ	LH	25	01/13/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/13/2009
Concurrent Drugs or Procedures:	physical exam & oral Strongid 1.1 ml

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: appointment (initial) was at 2:45 p.m. - owner brought pet back to practice @ 5:20 p.m. for severe facial swelling, erythema, prunitis. Temp 101, pulse 120, respiratory rate 60, mucous membranes pink. given 0.2 ml benadryl (50 mg/ml) IM, dexamethasone SP (4 mg/ml) 0.27 ml SQ, and SQ fluids (normosol) 100 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)	2.5 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) (Other Species):	Number in group: 1
Breed: Brussels Griffon	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 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): from Kentucky - a rescue group; previously given rabies (merial), DHPP & corona vaccine (unknown brand) and neutered by rescue group. was on pedigree diet.	

#### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Northern Rhode Island Animal Hospitals, Inc. 152 School Street, P.O. Box 129		Address: (b)(6)	
City: Forestdale		City: (b)(6)	
State: RI		State: MA	
Zip: 02824		Zip: (b)(6)	
*Phone: 401-762-2400(XXX-XXX-XXXX)		Phone: (b)(6) XXX-XXX-XXXX)	
FAX: 401-765-7679			
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:	401-762-2400(XXX-XXX-XXXX)

*Today's Date:	01/23/2009(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: 01/23/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09126

Product Code: 1905.24 13D1.20 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 Imrab 1 TF	298	110963	<input checked="" type="checkbox"/> Viral
2 Galaxy DA2PPvL	165A	212359A	<input checked="" type="checkbox"/> Viral
3 Bronchicine	189	A832120A	<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	01/16/2009
2 1 ml	SQ	L hip	25	01/16/2009
3 1 ml	SQ	Center above hips	25	01/16/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/16/2009
Concurrent Drugs or Procedures:	Strongid 1.1mL

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: pet vomitted 3 times post vaccine appointment pet recieved 3 vaccines and 1.1mL strongid PO came back in to clinic 1 hour later and recieved a Dexamethason injection IM. No problems afterwards.	

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"/> Low
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

### Animal Information

Case Identification:	Georgia	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:	American Eskimo	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.): second round puppy shots			

### Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name	(b)(6)
Address:	Family Friend Animal Hospital & Pet Lodge 229 Summerlin Blvd.	Address	(b)(6)
City:	Newnan	City	(b)(6)
State:	GA	State:	GA
Zip:	30265	Zip	(b)(6)
*Phone:	678-552-1717(XXX-XXX-XXXX)	Phone	(b)(6) (XX-XXX-XXXX)
FAX:	678-423-8368		
E-mail:	(b)(6)@familyfriendvet.com	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:	678-416-6759(XXX-XXX-XXXX)
*Today's Date:	01/20/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 01/20/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09125

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

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Bronchicine	189	A830928B	<input checked="" type="checkbox"/> Bacterial
2 Vanguard Plus 5	189	A829464C	<input checked="" type="checkbox"/> Viral
3 Vanguard CV	189	A826907A	<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		25	01/10/2009
2 1 ml	SQ		25	01/10/2009
3 1 ml	SQ		25	01/10/2009
4				

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

## Event Information

* Event description:	<input checked="" type="checkbox"/> Systemic
Explain the event and any treatment in a concise paragraph: Dog was lethargic for 2 days came back on 1/12/09 and was given Benadryl 50 mg and Dex 8 mg all 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)	not given
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:	31217	For animals handled in a group (herd, litter, etc.)	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	Labrador Retriever	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	0
Neutered:	<input checked="" type="checkbox"/> 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.):			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Animal Hospital of Redondo Beach 820 Torrance Blvd.	Address:	
City:	Redondo Beach	City:	
State:	CA	State:	
Zip:	90277	Zip:	
*Phone:	310-540-9044(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:	310-540-9044(XXX-XXX-XXXX)
*Today's Date:	01/19/2009(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: 01/19/2009

Verified: yes

Reviewed: yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09122  
 Product Code: 13D1.29 47A5.20

**\* 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	916310A	<input checked="" type="checkbox"/> Viral
2 CvK + B. Burgdorferi	112	338119A	<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	mid right thorax	25	01/13/2009
2 Administered at the same time as #1				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/13/2009
Concurrent Drugs or Procedures:	none

**Event Information**

\* Event description:  Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:  
 Puppy immediately started vomiting, then had bowel movements, dyspnea, and grey color mucus membranes. Puppy was immediately put on oxygen, given 200 ml fluids IV, give epinephrine IV, dexamethasone IV, and Diphenhydramine

IV. Puppy stabilized and was monitored at the clinic for 4 more hours. Owner picked up the puppy and called within an hour to say that the puppy was convulsing and had died. Puppy was brought back to the clinic and a necropsy performed.

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

**Animal Information**

Case Identification:	Sugar Desmarais	<b>For animals handled in a group (herd, litter, etc.)</b>	
*Species:	<input checked="" type="checkbox"/> Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed:	American Eskimo	Number vaccinated:	1
Sex:	<input checked="" type="checkbox"/> Female	Number dead:	1
Neutered:	<input checked="" type="checkbox"/> No		
Age (i.e., 2 yrs or 2 mos):	10 wks		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Acquired from breeder about 3 weeks previous. Had 2 Schering Plough distemper, cpv vaccines done at breeders.			

**Personal Information**

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Mill Valley Veterinary Clinic 224 Mill Valley Road	Address:	(b)(6)
City:	Belchertown	City:	(b)(6)
State:	MA	State:	MA
Zip:	01007	Zip:	(b)(6)
*Phone:	413-323-9201(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX)
FAX:	413-323-0290		
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:	413-323-9201(XXX-XXX-XXXX)
*Today's Date:	01/14/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 01/14/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09121

Product Code: 13D1.22 1905.24

**\* Required Fields**

**Product Information**

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Vanguard Plus 5	189	8721903691	<input checked="" type="checkbox"/> Viral
2 Defensor 3	189	8721900908	<input checked="" type="checkbox"/> Viral
3			
4			

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Withers	25	01/03/2009
2 1 ml	SQ	hip	25	01/03/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/03/2009
Concurrent Drugs or Procedures:	

**Event Information**

* Event description: <input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Gave DHPP & rabies on 1/3/09. Later returned with swollen lips & eyelids. Gave 50 g diph & 6 mg dexamethasone. Dog recovered & is doing fine.

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

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

### Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Golden Retriever	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos): 9 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):	

### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Southfork Animal Hospital 17445 Kenrick Avenue		Address:	
City: Lakeville		City:	
State: MN		State:	
Zip: 55044		Zip:	
*Phone: 952-892-7970(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:	952-892-7970(XXX-XXX-XXXX)
*Today's Date:	01/14/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 01/20/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09120

Product Code: 13D1.20 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Galaxy DA2PPvL	165A	212360B	<input checked="" type="checkbox"/> Viral
2 Defensor 1	165A	S723027B	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

## Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Intrascapular	24	01/02/2009
2 1 ml	SQ	RR	24	01/02/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/02/2009
Concurrent Drugs or Procedures:	Benedryl, Dexamethasone, oxygen therapy

## Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: 15 minutes after giving vaccinations dog started vomiting, defecating and getting very weak and pale. Administerd benedryl, dexametasone and gave oxygen therapy. Dog recovered fully in about 15 minutes after treatment	

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

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

### Animal Information

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Mini Schnauzer	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Female	Number dead: 0
Neutered: <input checked="" type="checkbox"/> No	
Age (i.e., 2 yrs or 2 mos): 15 wks	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):	

### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Hemlock Bluffs Animal Hospital 2968 Kildaire Farm Road		Address:	
City: Cary		City:	
State: NC		State:	
Zip: 27518		Zip:	
*Phone: 919-362-1223(XXX-XXX-XXXX)		Phone: (XXX-XXX-XXXX)	
FAX: 919-362-5087			
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:	919-362-1223(XXX-XXX-XXXX)

*Today's Date:	01/13/2009(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: 01/13/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09116

Product Code: 12X1.20 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 Bronchi-Shield III	112	112432C	<input checked="" type="checkbox"/> Combination
2 Duramune Max 5	112	916386A	<input checked="" type="checkbox"/> Viral
3 Rabvac 3 TF	112	873173A	<input checked="" type="checkbox"/> Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	Nasal	intranasal		01/05/2009
2 1 ml	SQ	L shoulder	22	01/05/2009
3 1 ml	SQ	R lateral thigh	22	01/05/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/05/2009
Concurrent Drugs or Procedures:	on frontline

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: vaccines given - dog became ataxic in shock within 10 mins. treated with diphenhydramine IM, dexamethasone sodium phosphate IV, IV fluids & oxygen.	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	approx 5-10 mins
Attending veterinarian's level of suspicion that product caused event:	<input checked="" type="checkbox"/> High
*Outcome (select one):	<input checked="" type="checkbox"/> Recovered with treatment
Other:	

**Animal Information**

Case Identification:	For animals handled in a group (herd, litter, etc.)
*Species: <input checked="" type="checkbox"/> Canine (Dog)	Number in group: 1
(Other Species):	Number affected: 1
Breed: Maltese	Number vaccinated: 1
Sex: <input checked="" type="checkbox"/> Male	Number dead: 0
Neutered: <input checked="" type="checkbox"/> Yes	
Age (i.e., 2 yrs or 2 mos): 1 yrs	
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): previous vaccines given 1 yr earlier without problems. On Pedigree Healthy Choice diet, lives in private home with family.	

**Personal Information**

Veterinarian		Owner	
*Name:	[Redacted]	Name:	[Redacted]
Address:	Newport Harbor Animal Hospital 125 Mesa Drive	Address:	[Redacted] (b)(6)
City:	Costa Mesa	City:	[Redacted]
State:	CA	State:	CA
Zip:	92677	Zip:	[Redacted]
*Phone:	949-631-1030(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	949-631-3354		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	<input checked="" type="checkbox"/> No
*Submitter's First Name:	[Redacted]
*Submitter's Last Name:	[Redacted]
*Submitter's Phone Number:	949-631-1030(XXX-XXX-XXXX)
*Today's Date:	01/09/2009(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: 01/09/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement: yes

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

# Adverse Event Report

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

Record Number: AIV09114

Product Code: 4637.20 1905.24

\* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Galaxy DA2PPvL	165A	213398A	<input checked="" type="checkbox"/> Combination
2 Defensor 1	189	S725737B	<input checked="" type="checkbox"/> Viral
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	IM	LR leg		01/07/2009
2 1 ml	IM	R side leg		01/07/2009
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/07/2009
Concurrent Drugs or Procedures:	dexamethasone injection

Event Information

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: After the animal was vaccinated with serial 213398A, it developed a anaphylactic reaction that lasted approximately 24 hrs.	

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

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

### Animal Information

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

### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name: (b)(6)	
Address: Family Friend Animal Hospital & Pet Lodge 229 Somerland Blvd		Address: (b)(6)	
City: Newnan		City: (b)(6)	
State: GA		State: GA	
Zip: 30265		Zip: (b)(6)	
*Phone: 678-552-1717(XXX-XXX-XXXX)		Phone: (b)(6) XX-XXX-XXXX)	
FAX: 678-423-8368			
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:	678-552-1717(XXX-XXX-XXXX)
*Today's Date:	01/08/2009(MM/DD/YYYY)

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

Submit

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

Date Received: 01/08/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09113

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	045141A	<input checked="" type="checkbox"/> Bacterial
2 LymeVax	112	229191A	<input checked="" type="checkbox"/> Bacterial
3 Bronchi-Shield III	112	112431B	<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	L hip	25	01/07/2009
2 1 ml	SQ	R hip	25	01/07/2009
3 1 ml	Intranasal	nose	-	01/07/2009
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/07/2009
Concurrent Drugs or Procedures:	

**Event Information**

* Event description:	<input checked="" type="checkbox"/> Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Vomited twice after vaccine was administered, no facial swelling.	
If this adverse event involves a possible lack of efficacy with a rabies product please	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1-2 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:	L8913-2	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 Dog	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 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:	Tates Creek Animal Hospital 4101 Tates Creek Centre Dr. Suite 146	Address:	
City:	Lexington	City:	
State:	KY	State:	KY
Zip:	40517	Zip:	(b)(6)
*Phone:	859-273-1933(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX
FAX:	859-273-1974		
E-mail:	tatescreekanimal@yahoo.com	E-mail:	n/a

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:	859-273-1933(XXX-XXX-XXXX)
*Today's Date:	01/07/2009(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: 01/07/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09111

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 Durammune Max 5	112	916341A	<input checked="" type="checkbox"/> Viral
2			<input checked="" type="checkbox"/> [Click arrow for selections]
3			<input checked="" type="checkbox"/> [Click arrow for selections]
4			<input checked="" type="checkbox"/> [Click arrow for selections]

**Administration of products.**

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RH leg	25	01/02/2009
2				
3				
4				

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/02/2009
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 ten minutes of vaccine administration, puppy vomited, became weak and within a few minutes collapsed with white mucous membranes and slow irregular heart rate. Had been given IM Benadryl prior to full collapse. After collapse, puppy was given IV Epinephrine, oxygen, IV fluids. Improved dramatically. However, vomiting resumed

several hours later and still quite lethargic. Treated with dexamethasone IM, Metoclopramide IM and SQ fluids. No further vomiting. Was still quiet the next day but eating and doing much better overall.

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:	Yasmine Servance	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"/> 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.): Got puppy one week before visit. No health problems, no abnormal exam findings prior to vaccine administration.			

#### Personal Information

Veterinarian		Owner	
*Name:	(b)(6)	Name:	(b)(6)
Address:	Westview Animal Hospital PA 5800 Johnnycake Road	Address:	(b)(6)
City:	Baltimore	City:	(b)(6)
State:	MD	State:	MD
Zip:	21207	Zip:	(b)(6)
*Phone:	410-744-4800(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX
FAX:	410-744-9498		
E-mail:	(b)(6)@gmail.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:	410-744-4800(XXX-XXX-XXXX)
*Today's Date:	01/05/2009(MM/DD/YYYY)
Relationship to animal:	<input checked="" type="checkbox"/> Veterinarian
Other:	

Submit

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

Date Received: 01/05/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement:

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

# Adverse Event Report

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

Record Number: AIV09110

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	045143A	<input checked="" type="checkbox"/> Bacterial
2			
3			
4			

Administration of products.

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

Administered by:	<input checked="" type="checkbox"/> Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/02/2009
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: Developed hives, facial swelling & vomiting 1-2 hrs post vaccination. Treated with diphenhydramine and dexamethasone.	

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

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1-2 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"/> Male	Number dead: 0	
Neutered: <input checked="" type="checkbox"/> Yes		
Age (i.e., 2 yrs or 2 mos): 5.5 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): seizure in 2003		

#### Personal Information

Veterinarian		Owner	
*Name: (b)(6)		Name:	
Address: Woodinville Veterinary Hospital 17646 140th Avenue NE		Address:	
City: Woodinville		City:	
State: WA		State:	
Zip: 98072		Zip:	
*Phone: 425-481-1184(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:	425-481-1184(XXX-XXX-XXXX)
*Today's Date:	01/05/2009(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: 01/05/2009

Verified:yes

Reviewed:yes

Date Entered: 03/06/2009

CVB Reporter:

Acknowledgement:

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

Canine 5-Way Vaccines (Based on True Name) - Doses Produced CY 2009

FOIA 11-091

Product Code	True Name	Trade Name	Doses Produced	Firms Producing
1599.20	Canine Distemper-Adenovirus Type 2-Coronavirus-Parainfluenza-Parvovirus Vaccine, Modified Live & Killed Virus	Galaxy DA2PPv+Cv; Vanguard 5/CV	0	Est. 165A, Intervet (former #286)/Schering-Plough Animal Health; Est. 189, Pfizer Animal Health
1599.21	Canine Distemper-Adenovirus Type 2-Coronavirus-Parainfluenza-Parvovirus Vaccine, Modified Live & Killed Virus	Duramune DA2PP+CvK; Vanguard Plus 5/CV	0	Est. 112, Fort Dodge Animal Health (now #124, Boehringer-Ingelheim Vetmedica, Inc.); Est. 165A, Intervet (former #286)/Schering Plough Animal Health; Est. 189, Pfizer Animal Health
1599.25	Canine Distemper-Adenovirus Type 2-Coronavirus-Parainfluenza-Parvovirus Vaccine, Modified Live & Killed Virus	Duramune Max 5-CvK (The Puppieshot)	0	Est. 112, Fort Dodge Animal Health (now #124, Boehringer-Ingelheim Vetmedica, Inc.)
1599.29	Canine Distemper-Adenovirus Type 2-Coronavirus-Parainfluenza-Parvovirus Vaccine, Modified Live & Killed Virus	Duramune Max 5-CvK (The Puppieshot)	0	Est. 112, Fort Dodge Animal Health (now #124, Boehringer-Ingelheim Vetmedica, Inc.)
<b>Total Doses Produced</b>			<b>0</b>	

*NOTE: Based on the Product True Name, the above four products are the only canine products that the Center for Veterinary Biologics considers true 5-way vaccines produced by the firms identified in the FOIA inquiry. Other products produced by these firms that include the trade names listed in the inquiry ("DuraMune", "Vanguard 5", "Galaxy 5", and "Solojec"), may include only some of the five components, or those five components plus others.*