PVN #

SMALLPOX VACCINATION DIARY

Instructions:
This diary card is an essential source of information to the WV Bureau for Public Health regarding symptoms that may be associated with the smallpox vaccine. In addition, it will serve as a memory aid for anyone participating in the telephone follow-up surveys at days 10 and 21 following vaccination. All information on this card is confidential. Information that could be used to identify you will not be made public. Your participation is voluntary and will in no way impact any treatment you may require. If you have questions about the card or your participation, please call Dr. Neely Kaydos-Daniels at 304-558-3580.

It is very important that this diary card be completed daily beginning with the day of the vaccination (Day 0).

In the section entitled "**Summary Information**" indicate the day the scab fell of and any days that you missed work for health reasons that you believe are due to the smallpox vaccine by entering an "**X**" in the appropriate box.

In the sections entitled "**Symptoms**", "**Vaccination Site**", and **"Other"** enter a "**0**" for any days you did not have the symptom or skin finding listed. For any days that you have a symptom or skin finding, use the scale included to grade the severity of the symptoms by entering by entering a "**1**", "**2**", or "**3**" in the appropriate box for that day.

Please fill out the diary daily through day 21. On day 22, or after the scab has fallen off, whichever is later, return the completed diary card to your Vaccine Safety Monitor or Health Department. Please do not delay in returning the card.

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	DATE OF VACCINATION

ADDRESS	HOME TELEPHONE #	GENDER	PREVIOUS SMALLPOX VACCINATION
		□ Male □ Female	□ Yes □ No □ Don't know If Yes, Year____

RACE:	ETHNICITY: Hispanic Origin □Yes □No	CONTRAINDICATIONS
□ American Indian or Alaskan Native	□ Mexican	□ None
□ Asian	□ Puerto Rican	□ Close contact with contraindication
□ Black or African American	□ Cuban	□ I have a contraindication
□ Native Hawaiian or other Pacific Islander	□ Central American	□ History of atopic dermatitis or eczema
□ White	□ South American	□ Immunosuppression (for any reason)
□ Other	□ Spanish origin	□ Pregnancy
	□ Other Latin American	□ I prefer not to tell why I am contraindicated

Occupation: _____

Where do you work? □ Hospital □ Health Department □ Other (Describe:_____)

Please describe the amount of information you received about the risks of smallpox vaccination:
- □ Too little information
- □ The right amount
- □ Too much information

Date scab fell off: _____

PLEASE USE THE FOLLOWING SCALE TO GRADE SYMPTOMS YOU EXPERIENCE FOLLOWING VACCINATION. ENTER THE APPROPRIATE NUMBER INTO THE CORRESPONDING BOX FOR SYMPTOMS WITH NEW ONSET FOLLOWING VACCINATION

CODE	GRADE	DESCRIPTION
1	Mild	Does not interfere with daily activities
2	Moderate	Interferes with routine activities
3	Severe	Unable to perform routine activities

DAY NUMBER

The day of the vaccination is denoted as Day 0 and the others numbers follow sequentially.

WRITE IN DATE ►																						
SYMPTOMS	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**
No symptoms (indicate with an "X")																						
Fever (record temperature)																						
Chills																						
Tired, lethargic, fatigued																						
Change in sleep pattern																						
Muscle Pain (other than at injection site)																						
Joint Pain, swelling/ inflammation																						
Headache																						
Backache																						
Itching: at vaccination site																						
Itching (other than at vaccination site)																						
Abdominal pain																						
Nausea																						
Loss of appetite																						
Difficulty Breathing/wheezing																						
Cough																						
Swollen/tender lymph nodes																						
VACCINATION SITE	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**
Redness>3inches near site?																						
Swelling at injection site																						
Pain/tenderness																						
Streaks on arm																						
OTHER	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**

PLEASE CONSULT YOUR VACCINE SAFETY MONITOR IF YOU (OR A CONTACT) EXPERIENCE ANY OF THE FOLLOWING. MEDICAL EVALUATION IS RECOMMENDED.

Rash – any type (blotchy, bumps, red, scaly, dry, sores, looks like vaccination site, etc.)																						
Eye Problems – inflammation, infection, vision problems, etc.																						
Household member or close contact with any type of rash																						
Describe the above:																						

SUMMARY INFORMATION (Mark with an 'X')	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21-28**
Missed work due to vaccination symptoms																						
Saw Vaccine Safety Monitor																						
Saw Physician due to vaccination																						

PHYSICIAN/HOSPITAL NAME AND TELEPHONE NUMBER: