

Vaccine Storage Troubleshooting Record (check one) ☐ Refrigerator ☐ Freezer ☐ Ultra-Cold Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of vaccines to temperatures that are outside the manufacturers' recommended storage ranges.

Date & Time of Event If multiple, related events occurred, see Description of Event below.	Storage Unit Temperature at the time the problem was discovered		Room Temperature at the time the problem was discovered	Person Completing Report	
Date:	Temp when discovered:		Temp when discovered:	Name:	
Time:	Minimum temp:	Maximum temp:	Comment (optional):	Title:	Date:
Description of Event <i>(If multiple, related events occurred, list each date, time, and length of time out of storage.)</i> - General description (i.e., what happened?) - Estimated length of time between event and last documented reading of storage temperature in acceptable range (2° to 8°C [36° to 46°F] for refrigerator; -50° to -15°C [-58° to 5°F] for freezer; (-90°C to -60°C [-130°F to -76°F]) for ultra-cold freezer. - Inventory of affected vaccines, including (1) lot numbers and (2) whether purchased with public (for example, VFC) or private funds. Document this information on the <i>Vaccine Storage Emergency Response Worksheet</i> (see www.immunize.org/catg.d/p3051) or a separate sheet, and maintain the inventory with this troubleshooting record. - At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer? - Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine? - Include any other information you feel might be relevant to understanding the event.					
Action Taken <i>(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)</i> - When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].) - Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.) - IMPORTANT: What did you do to prevent a similar problem from occurring in the future?					
Results What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)					

