



MISSOURI DEPARTMENT OF
HEALTH &
SENIOR SERVICES



Strategic National Stockpile: Point of Dispensing Training

[Instructor Name]

[Instructor Title]

[Instructor Agency]



MISSOURI DEPARTMENT OF
**HEALTH &
SENIOR SERVICES**



Unit 1:

Strategic National Stockpile (SNS) Dispensing

Introductions

- ▶ [Instructor Name]
 - ▶ [Instructor Title]
 - ▶ [Instructor Agency]
- ▶ Your Turn!
 - ▶ Name
 - ▶ Health Department Affiliation
 - ▶ Experience working with dispensing medications or administering vaccinations?

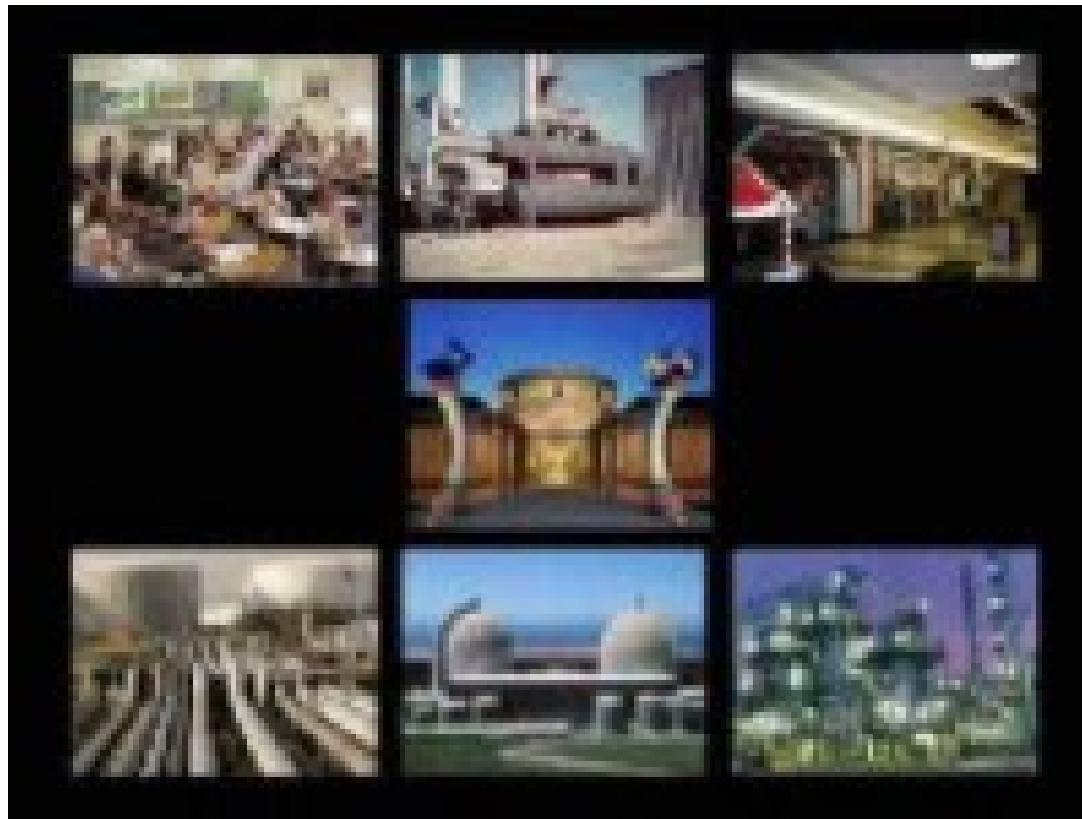
Course Goal

Provide an orientation to the specific terms and procedures to follow in accordance with Federal and State guidance when dispensing medications during a governor-declared state of emergency in Missouri

Course Objectives

- ▶ Summarize the Strategic National Stockpile (SNS) Program
- ▶ List applicable state and federal laws/regulations
- ▶ Discuss techniques for safely administering medications

POD Training Video Part 1



POD Training Video Part 2



What is a
POD?



What is a POD?

- ▶ Not to be confused with Points of Distribution, Points of Dispensing (PODs) are sites used to dispense life-saving medications in an emergency
 - ▶ For distribution of medication, not treatment
 - ▶ Can be used for large scale incidents such as natural disasters, terrorist attacks, or other public health emergencies

Types of PODS

- ▶ Open (Public) PODs: Dispensing sites operated by Public Health Agencies which serve the general public
- ▶ Closed (Private) PODs: Dispensing sites operated by businesses/organizations in partnership with Public Health Agencies, which serve designated populations and relieve overcrowding at public PODs

Why Use PODs?

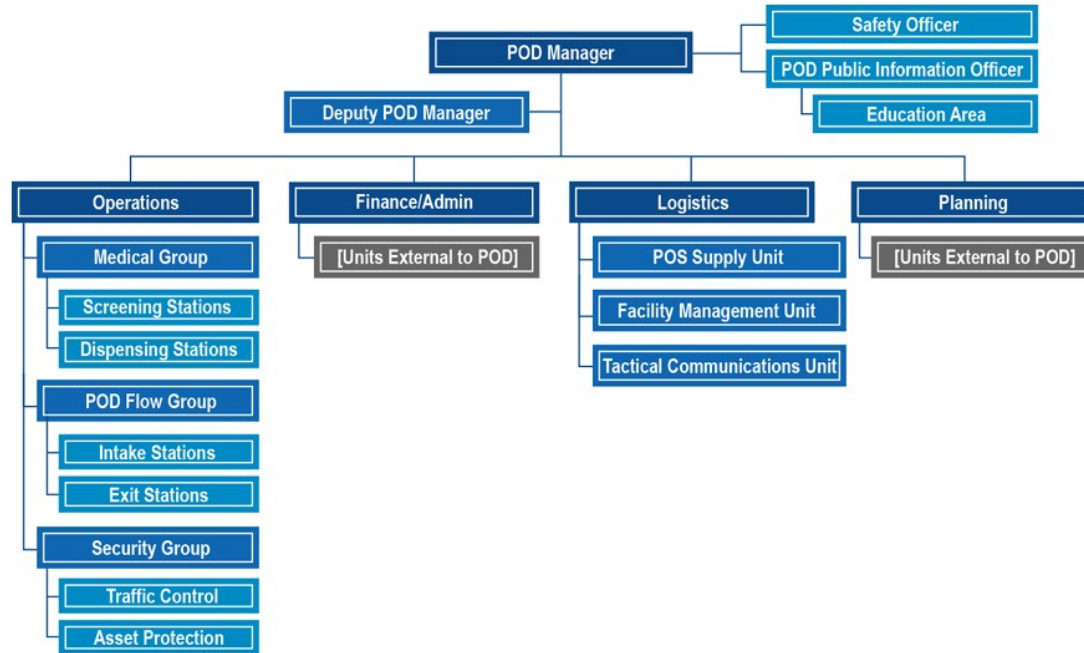
- ▶ Increase the speed at which medication reaches the community
- ▶ Decrease the number of individuals who may become ill
- ▶ Provide timely information



POD Operations

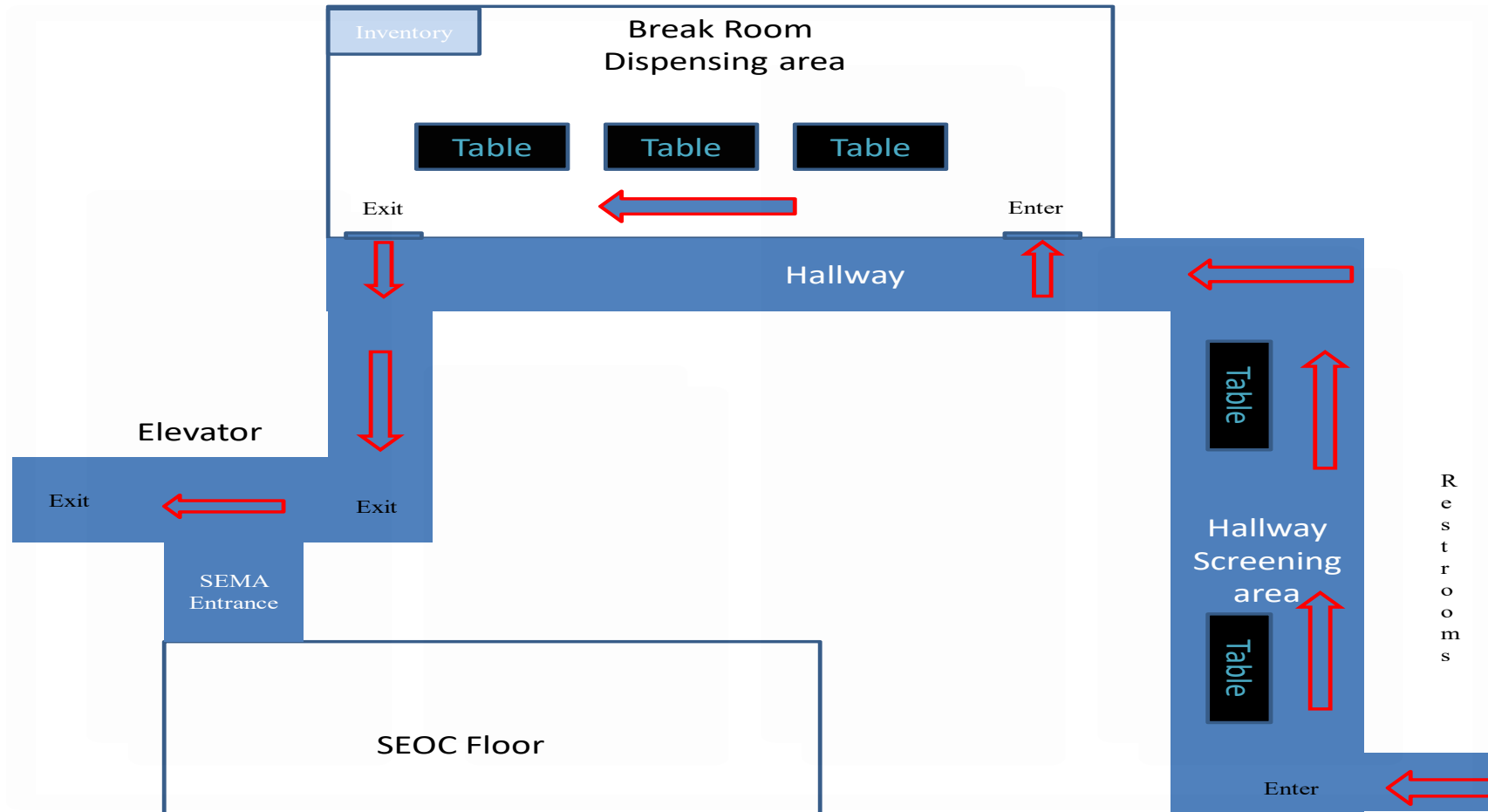
- ▶ All PODS require the same basic operations, but how they are carried out depends on the plans for each specific POD site and for the jurisdiction overall
 - ▶ All PODS need some form of:
 - ▶ Greeting
 - ▶ Triage
 - ▶ Registration
 - ▶ Screening
 - ▶ Dispensing
 - ▶ Patient Education
 - ▶ These roles can be combined or further divided as needed

POD Command Structure

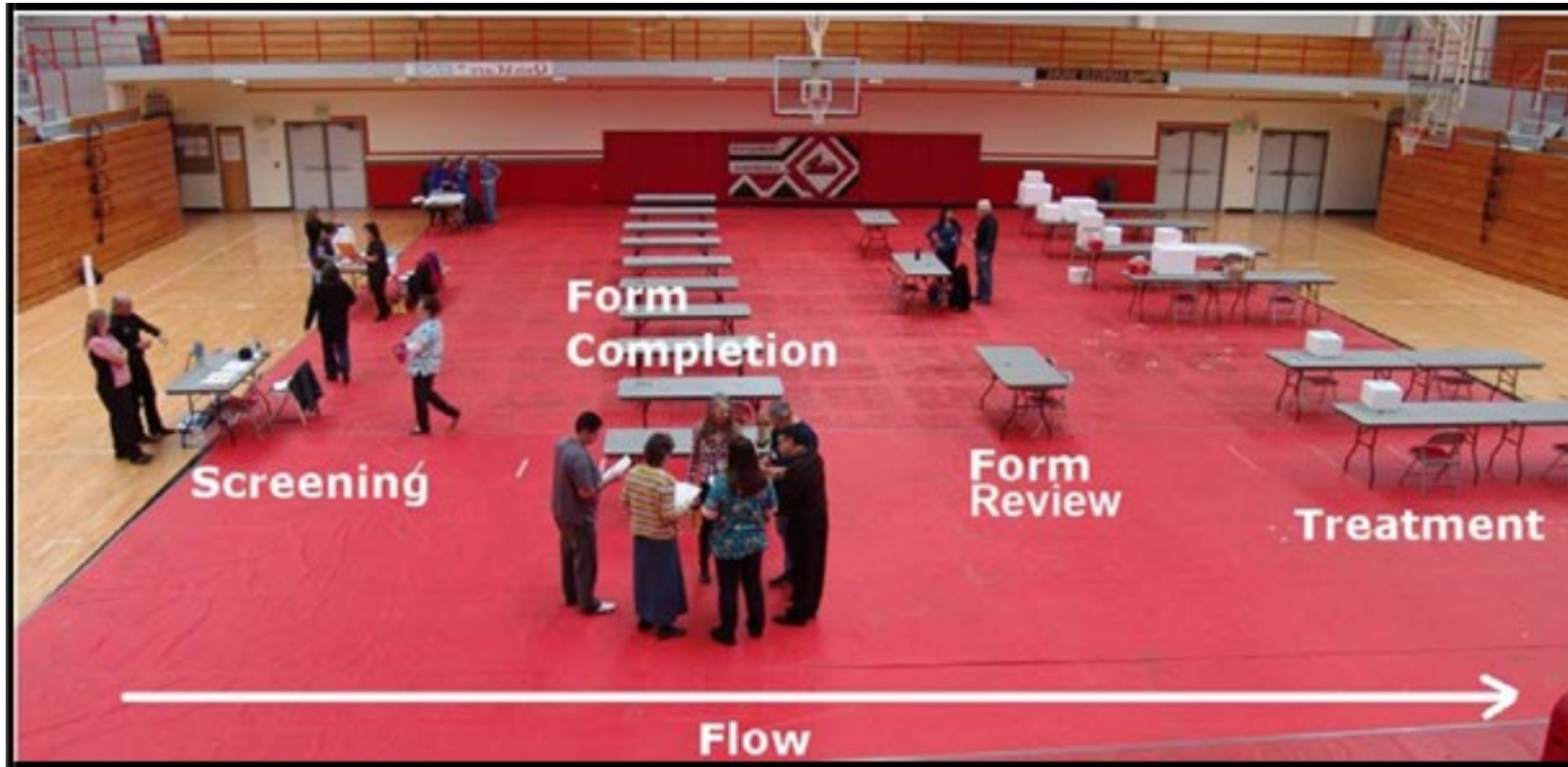


- ▶ Recommended to use an Incident Command System Model
 - ▶ Allows for flexibility in staffing and scaling as needed
- ▶ The chain of command, POD roles used, or other site-specific information should be determined by the local jurisdiction

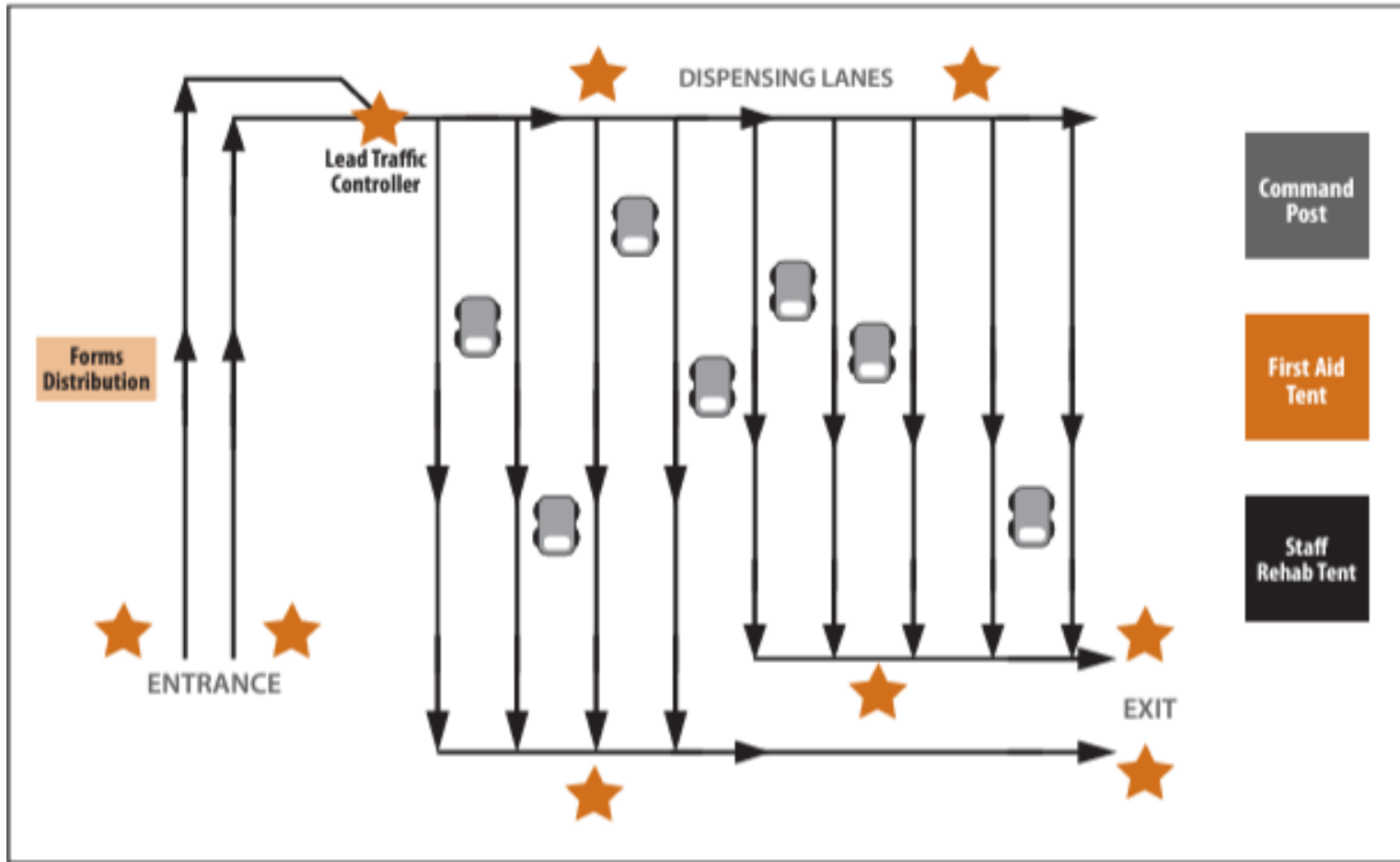
Small Closed POD



Medium Open POD



Large Drive Through POD



★ = Traffic Controllers

Additional POD Resources

- ▶ Information on POD structure and operations are to be provided by the respective jurisdiction
- ▶ Additional training can be found at CDC Train (<https://www.train.org/cdctrain/welcome>)
- ▶ Best practices and POD Throughput Calculators are available in Annex G of the State's SNS plan



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Unit 2:

Strategic National Stockpile (SNS) Overview

Objectives

- ▶ Summarize the Strategic National Stockpile (SNS) Program by:
 - ▶ Describing when the SNS may be deployed
 - ▶ Listing the categories of assets available through the SNS
 - ▶ Describe the process for requesting SNS assets

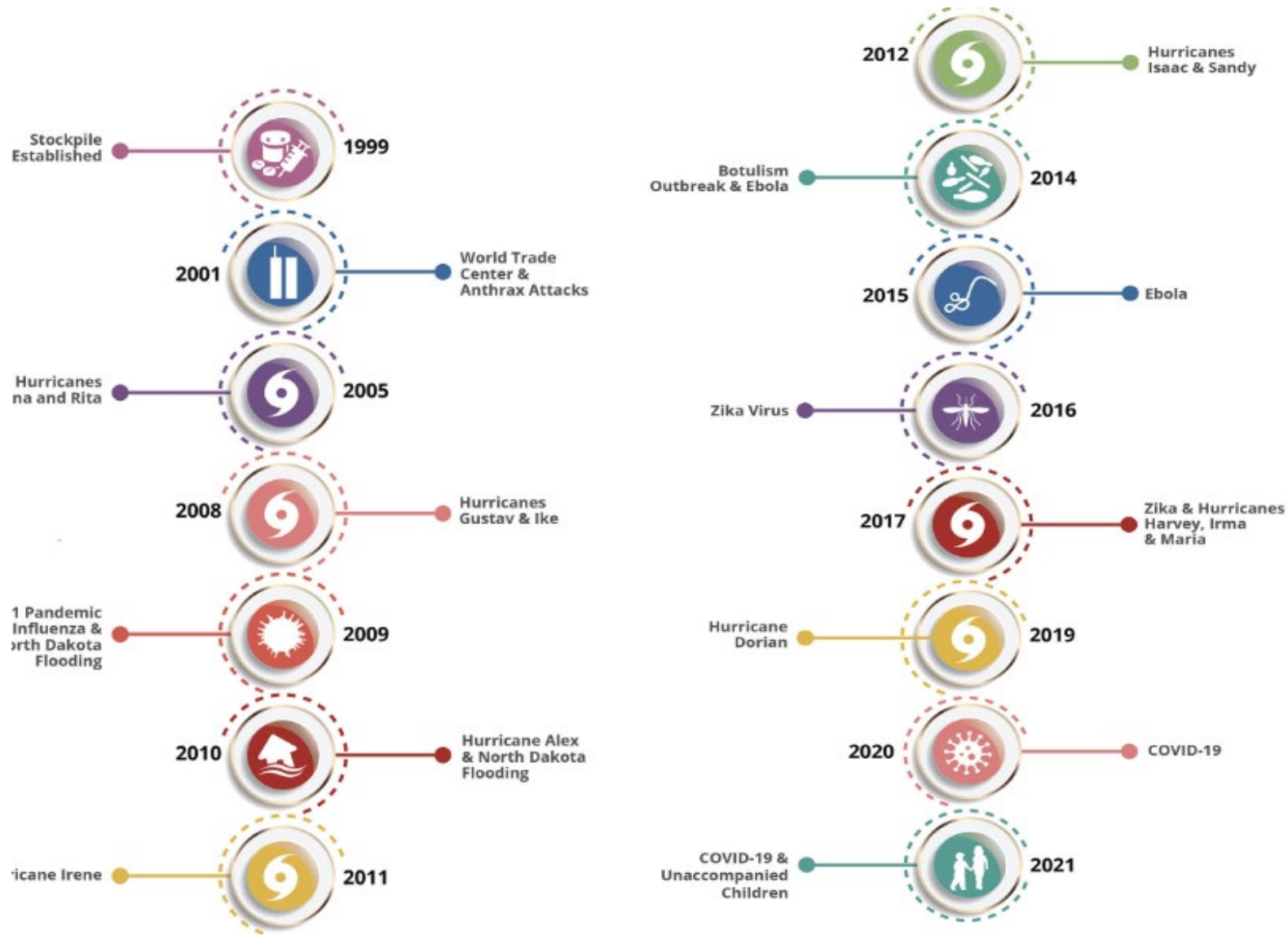
SNS History



- ▶ 1999: Congress establishes the National Pharmaceutical Stockpile
 - ▶ The NPS was made to provide impacted populations necessary pharmaceuticals within 12 hours
- ▶ 2003: The National Pharmaceutical Stockpile was renamed to the Strategic National Stockpile
 - ▶ The SNS is the nation's largest supply of medical countermeasures
 - ▶ SNS is not a first response and SNS assets are only for use when local supplies have been exhausted

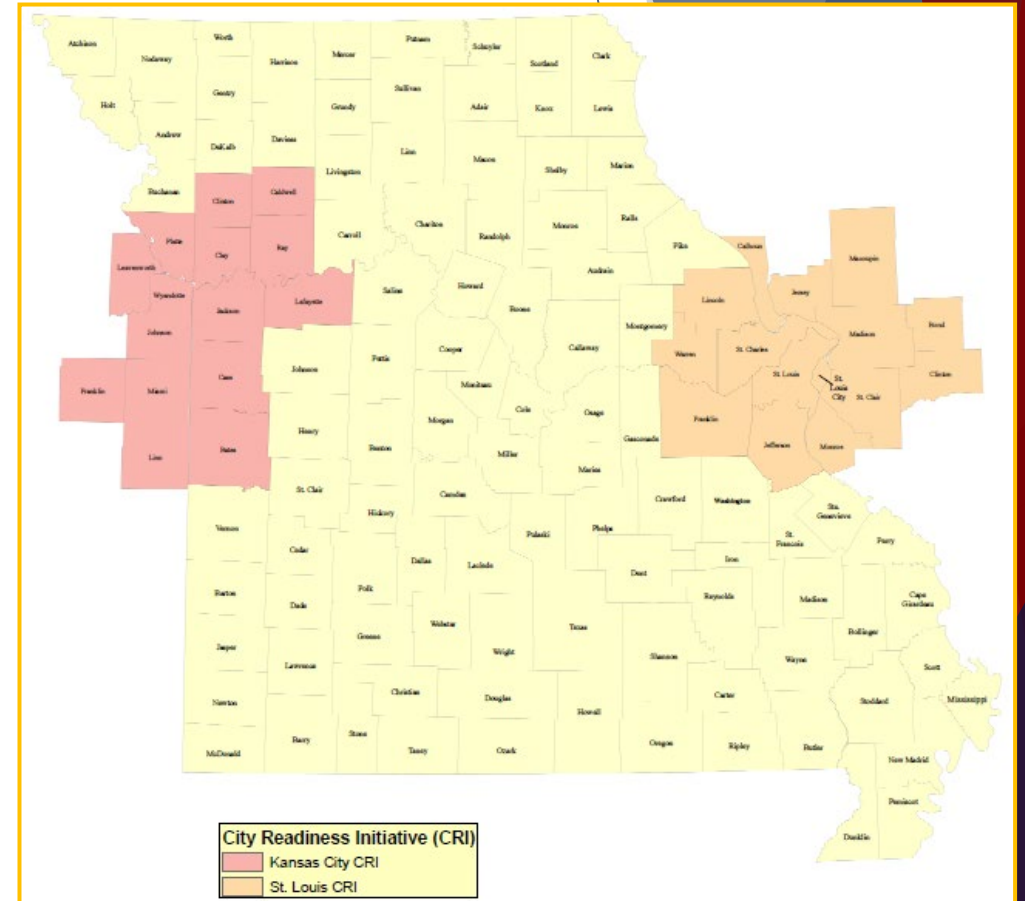


SNS Timeline



Public Health Readiness: Cities Readiness Initiative (CRI)

- ▶ CRI was established in 2004 to enhance preparedness in the largest cities of the US
- ▶ Based on aerosolized Anthrax threat
- ▶ Goal: Provide mass prophylaxis to 100% of the community within 48 hours
- ▶ Population of Missouri 6,196,156 (2023 Census Data)



Public Health Emergencies: Category A Pathogens

The following slides provide an introduction to these potential biohazard threats, but are not intended to be a clinical discussion of diseases

Public Health Emergencies: Category A Pathogens

- ▶ Category A Pathogens are those biological agents that pose the highest risk to national security and public health because they:
 - ▶ Can be easily disseminated or transmitted
 - ▶ Result in high mortality rates
 - ▶ Might cause public panic and social disruption
 - ▶ Require special action for public health preparedness
- ▶ Category A Pathogens include:
 - ▶ Anthrax (*Bacillus anthracis*)
 - ▶ Botulism (*Clostridium botulinum* toxin)
 - ▶ Plague (*Yersinia pestis*)
 - ▶ Smallpox (variola major)
 - ▶ Tularemia (*Francisella tularensis*)
 - ▶ Viral Hemorrhagic Fevers
 - ▶ Arenaviruses (Lassa, Lujo, and others)
 - ▶ Bunyaviruses (Crimean-Congo Hemorrhagic Fever, and others)
 - ▶ Flaviviruses (Dengue)
 - ▶ Filoviruses (Ebola, Marburg)



Anthrax

- ▶ Anthrax is a serious infections disease caused by gram-positive, rod-shaped bacteria known as *Bacillus anthraxis*
- ▶ Which of the four types of Anthrax a person develops depends on how the spores enter the body, but note that Anthrax is **NOT CONTAGIOUS**
- ▶ *Bacillus anthracis* is one of the most likely biological agents to be used in a bioterrorist attack



Botulism

- ▶ Botulism is a rare, but serious, illness caused by a toxin produced from bacteria known as *Clostridium botulinum*, and rare strains of *Clostridium butyricum* and *Clostridium baratii*
- ▶ Botulinum toxin is one of the most lethal toxins known and attacks the body's nerves causing difficulty breathing, muscle paralysis, and death
- ▶ Although the greatest threat of Botulinum toxin may be by aerosol use, the more likely threat may be the deliberate contamination of food or drink

A microscopic view of several Yersinia pestis bacteria, which are rod-shaped and have a distinct internal structure, set against a reddish-brown background.

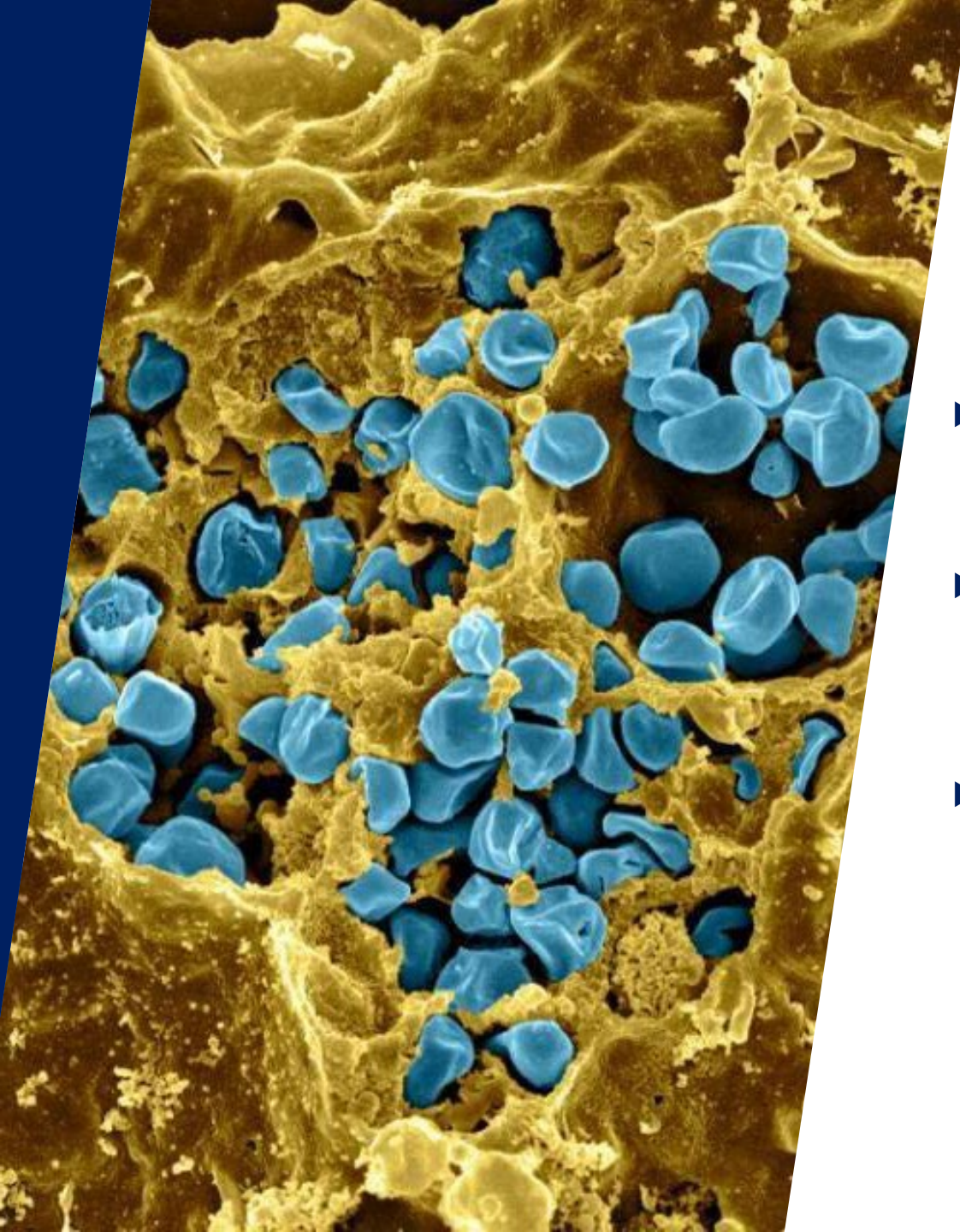
Plague

- ▶ Plague is an infectious disease caused by *Yersinia pestis*, a bacteria found in many areas of the world
- ▶ Plague can take different clinical forms depending on how the patient was exposed to the plague bacteria, but the most common are bubonic, pneumonic, and septicemic
- ▶ A bioweapon carrying *Yersinia pestis* used in an aerosol attack could cause cases of the pneumonic form of plague, which can be spread from person to person

An electron micrograph showing several smallpox virus particles. Each particle consists of a red, brick-shaped core (nucleoid) surrounded by a blue cytoplasmic layer and an outer green, textured envelope. The particles are scattered across the field of view.

Smallpox

- ▶ Smallpox is a serious and highly contagious infectious disease caused by the variola major virus
- ▶ The eradication of smallpox, declared 05/08/1980 by the World Health Assembly, is considered the greatest achievement in international public health
- ▶ The risk for an intentional or accidental release of the smallpox virus is believed to be low, but the effects of such an event could be devastating, so even one confirmed case of smallpox today would be considered an emergency



Tularemia

- ▶ Tularemia, also known as “Rabbit Fever,” is a potentially serious illness that is caused by the bacterium *Francisella tularensis*
- ▶ Tularemia occurs naturally in the US and a widespread disease in animals, particularly rodents, rabbits, and hares, but it can be spread to humans
- ▶ If *Francisella tularensis* was made airborne as a weapon, people who inhale the aerosol will generally experience severe respiratory illness, including life threatening pneumonia and systemic infection



Viral Hemorrhagic Fevers

- ▶ Viral Hemorrhagic Fevers (VHFs) refer to a group of illnesses caused by highly infectious viruses that, among other multisystem symptoms, are often accompanied by hemorrhage (bleeding); however the bleeding itself is rarely life-threatening
- ▶ While some types of VHFs can cause relatively mild illnesses, many of these viruses cause severe, life-threatening disease
- ▶ Some VHFs, including Ebola, Marburg, Dengue, and Lassa, are considered a significant threat for use as biological weapons

Additional Resources

- ▶ For more information on each disease threat/agent:
 - ▶ CDC's Website
 - ▶ <https://emergency.cdc.gov/bioterrorism/>
 - ▶ VDV's App "Field Facts" (available for free download)
 - ▶ USAMRID's reference guide "Quick Bio-Agents"

SNS Contents

- ▶ Organized for scalable response to a variety of public health threats, the SNS contains a variety of supplies, and of sufficient quantity to respond to multiple large-scale emergencies simultaneously
- ▶ Starts with a “12-Hour Push Package” then switches to “Managed Inventory”



SNS Contents

▶ 12-Hour Push Package:

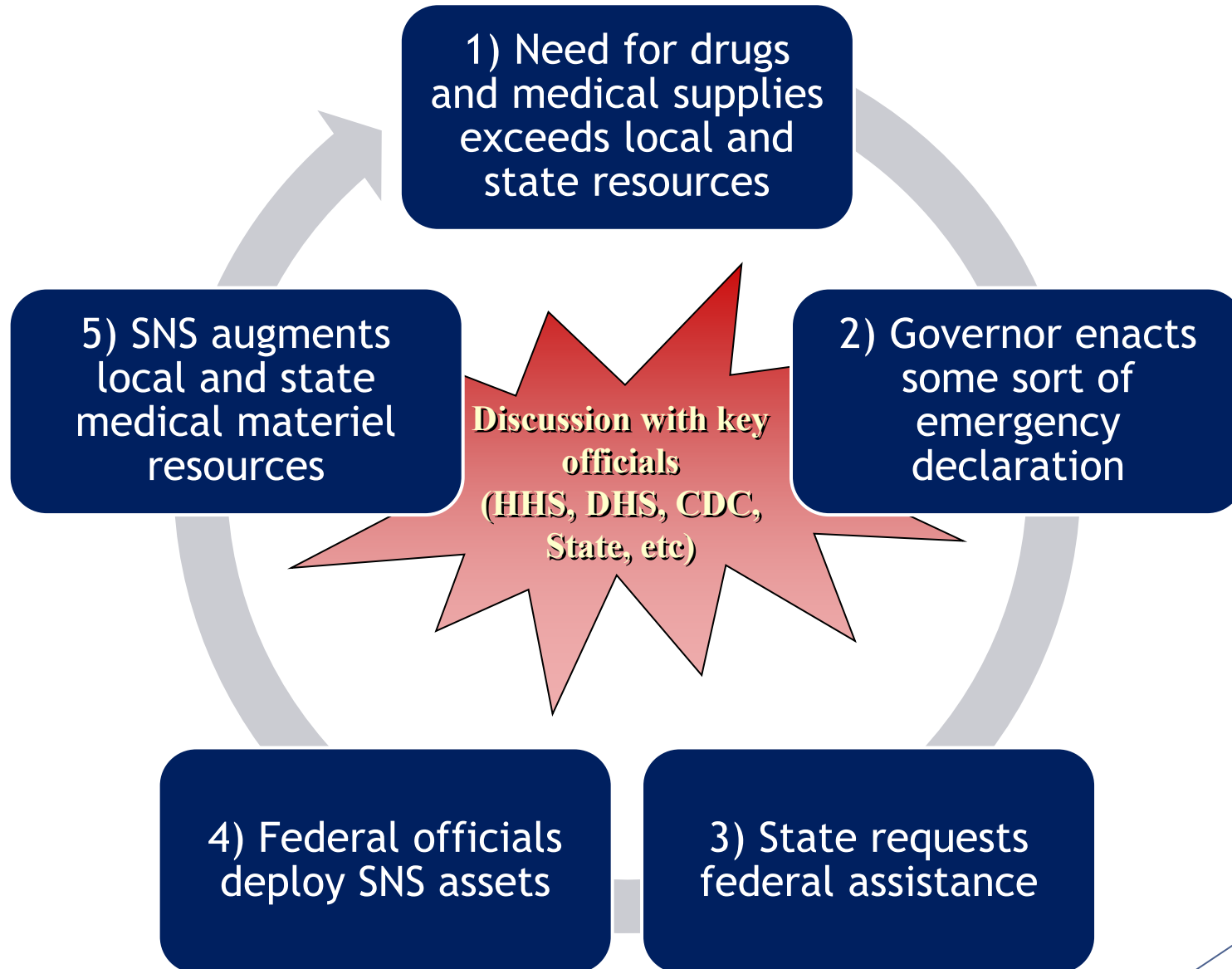
- ▶ Broad spectrum antibiotics
- ▶ IV Fluids/Admin Kits
- ▶ Airway Equipment
- ▶ Items for radiation blasts/burns/injuries
- ▶ Wound care

▶ Managed Inventory

- ▶ Antibiotics
- ▶ Vaccines
- ▶ Antitoxins
- ▶ Ventilators
- ▶ More 12-Hour Push Package Items



Requesting SNS Materials



Unit 2 Discussion

- ▶ When might the SNS be deployed?
- ▶ What assets are available through the SNS?
- ▶ Describe the process for requesting SNS assets



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Unit 3:

Legislation

Objectives

- ▶ Discuss Federal and State Laws regarding dispensing, liability, protection, and labeling
- ▶ Discuss dispensing and liability protection for volunteers
- ▶ Explain what an “Emergency Use Authorization” is used for
- ▶ Describe how the Health Insurance Portability and Accountability Act (HIPAA) applies to mass prophylaxis dispensing operations

Liability Protection

- ▶ Federal Level

- ▶ Public Readiness and Emergency Preparedness (PREP) Act

- ▶ State Level

- ▶ Missouri Code of State Regulations (19 CSR 20-44.010)

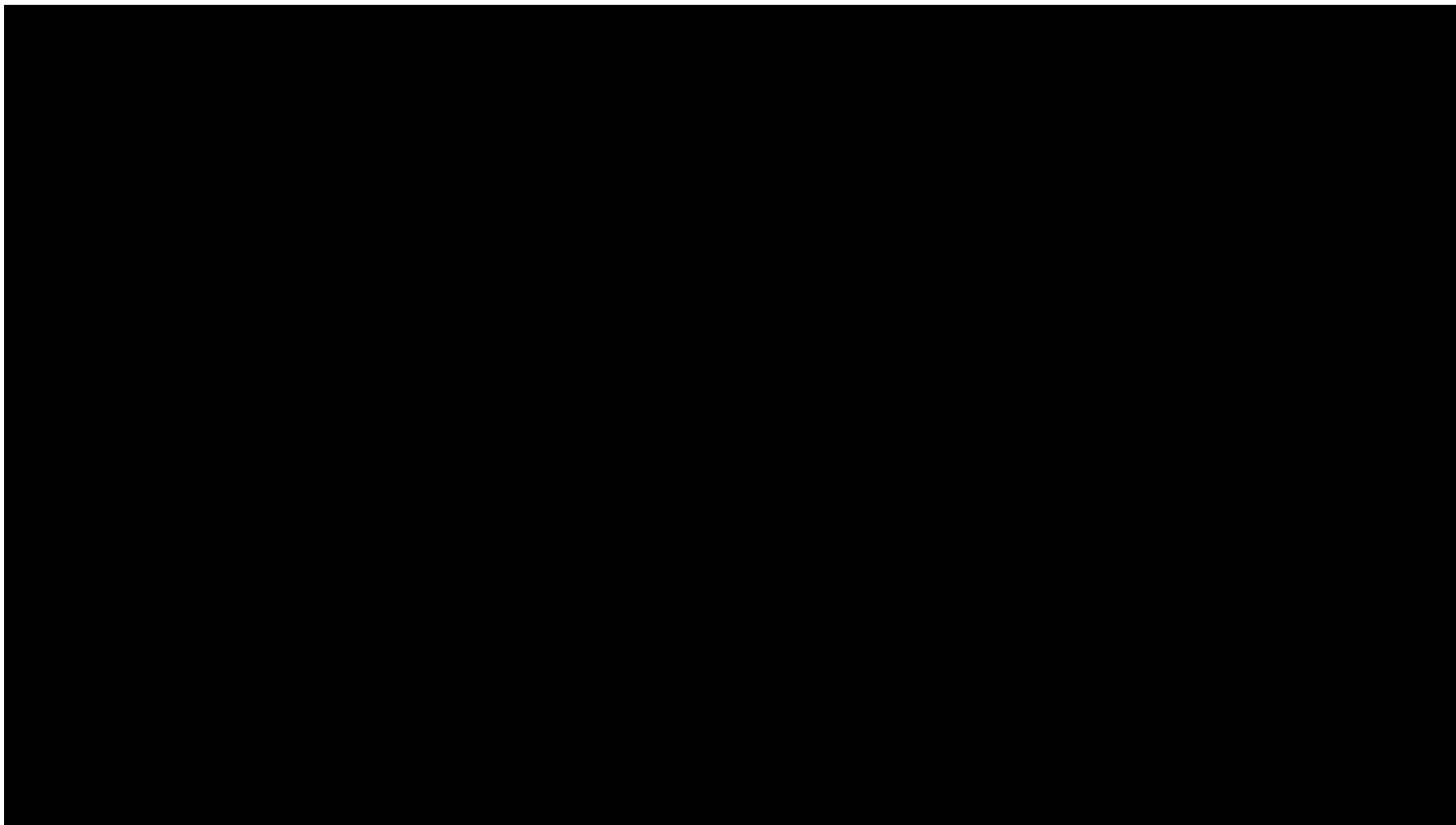
PREP Act

- ▶ The PREP Act authorizes the Secretary of the Department of Health and Human Services (“Secretary”) to issue a PREP Act Declaration that provides immunity from tort liability (except for willful misconduct)
- ▶ Applicable for claims of loss caused, arising out of, relating to, or resulting from the administration or use of countermeasures to diseases, threats, and conditions determined by the Secretary to constitute a present or credible risk of a future public health emergency

PREP Act

- ▶ Protects entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures
- ▶ A PREP Act Declaration is specifically for the purpose of providing immunity from tort liability, and is different from and not dependent on, other emergency declarations

PREP Act



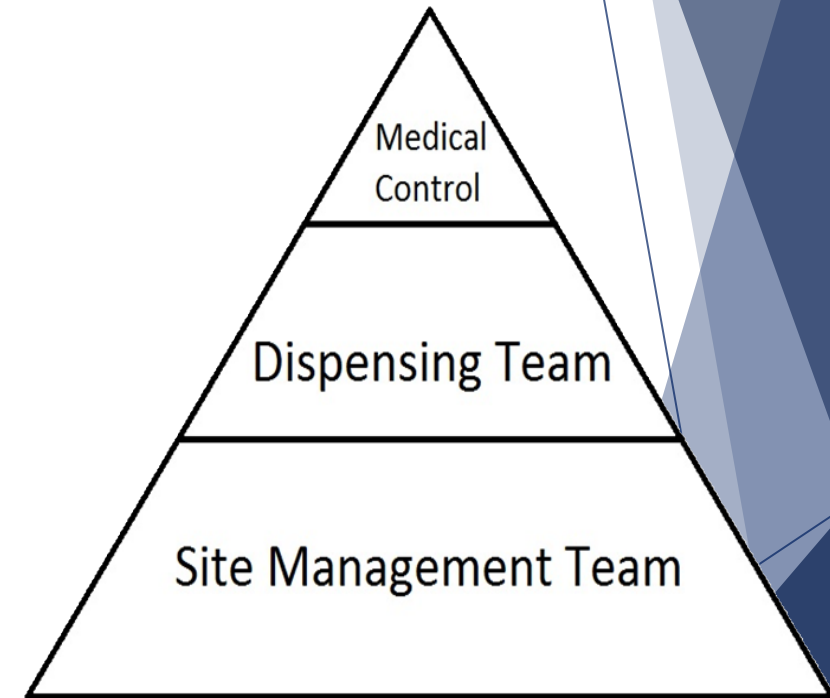
19 CSR 20-44.010

- ▶ *The Department may develop citizen involvement to recruit, train and accept the services of volunteers to supplement the programs administered by the Department in dispensing medications to the population in the event of an emergency*
 - ▶ Allows for the deployment of health care professionals, licensed, registered, or certified in Missouri or any other state in an emergency and grants them immunity from civil damages



POD Roles

- ▶ Medical Control Team
 - ▶ Requires written orders and medical guidance
- ▶ Dispensing Team
 - ▶ Requires authorization by DHSS
- ▶ Site Management Team
 - ▶ Requires the knowledge of POD operations and logistics



Maintaining Certifications

- ▶ Certification card will be mailed to individuals upon course completion
- ▶ Dispenser certification is valid for 3 years
- ▶ Certification does NOT require registering in Show-Me Response Volunteer Database, but is encouraged

Emergency Use Authorization

Emergency Use Authorization of Medical Products and Related Authorities

Guidance for Industry and Other Stakeholders

U.S. Department of Health and Human Services
Food and Drug Administration
Office of the Commissioner
Office of the Chief Scientist
Office of Counterterrorism and Emerging Threats

January 2017

Procedural
OMB Control No. 0910-0595
Expiration Date 09/30/2025

See additional PRA statement in section IX of this guidance.

Medical Products Subject to an EUA

- ▶ Products can include Drugs, Biologics, and Medical Devices
- ▶ Some products may have NEVER been approved
- ▶ May have been approved for some other use, but not for the use required by the emergency

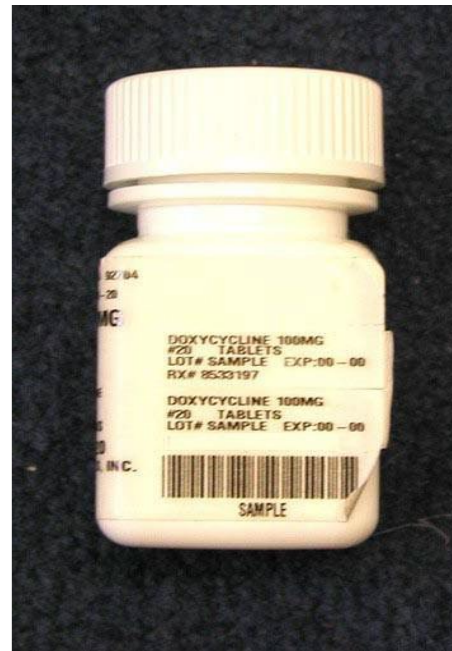
How must prescription drugs be dispensed?

- ▶ 21 U.S.C. § 353(b)(1): Regulates how prescription drugs must be dispensed, including what its label must contain
- ▶ The information on the label must be present regardless of how the prescription was written
 - ▶ This includes:
 - ▶ A written prescription
 - ▶ An oral prescription (reduced promptly to writing); or
 - ▶ A refilling of a prescription

Federal Label Requirements



Unit of Use Bottles



SNS Labels


1

2

3

PACKAGED BY DISPENSING SOLUTIONS, INC.
SANTA ANA, CA 92704
MANUFACTURED BY IVAX PHARMACEUTICALS, INC.
MIAMI, FL 33137

NDC 66336-449-20


2D BARCODE

STORE AT 20°-25°C (68°-77°F)
[SEE USP CONTROLLED ROOM TEMPERATURE].


FOR STRATEGIC NATIONAL
STOCKPILE USE ONLY

DOXYCYCLINE 100 mg

EACH TABLET CONTAINS:
DOXYCYCLINE HYCLATE
EQUIVALENT TO DOXYCYCLINE
100 mg, FD&C YELLOW #6.

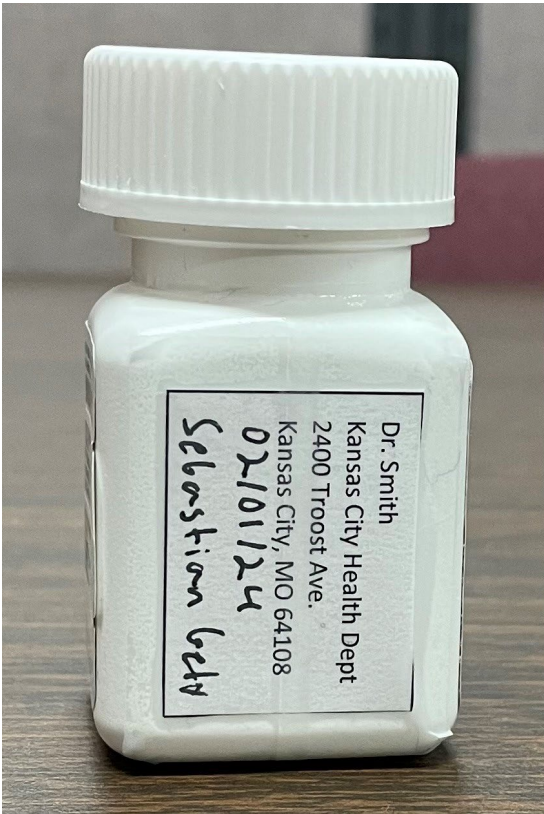
20 TABLETS
**USUAL DOSAGE: Take one
tablet every 12 hours.**

RX ONLY

LOT# S01330 EXP: Sep-07
RX# 1000000001 (999-9999)

DOXYCYCLINE 100 mg
20 TABLETS
LOT# S01330 EXP: Sep-07
RX# 1000000001
NDC 66336-449-20
DOXYCYCLINE 100 mg
20 TABLETS
LOT# S01330 EXP: Sep-07
RX# 1000000001
NDC 66336-449-20

KEEP OUT OF THE REACH OF CHILDREN
DISPENSE IN THIS TIGHT, LIGHT
RESISTANT CONTAINER

Information You Need to Include



- ▶ Name of prescriber
- ▶ Name of address of dispenser
- ▶ Date prescription filled
- ▶ Patient Name

Health Insurance Portability and Accountability Act - HIPAA

- ▶ Major Goal:

- ▶ Assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being

Strategies to Follow HIPAA

- ▶ Have materials on HIPAA Basics ready for volunteers
- ▶ Proper handling and storage of sensitive documents
- ▶ Make sure that you are speaking at an appropriate volume
- ▶ Make sure there is adequate space and distance between lines and dispensers
- ▶ Don't get too in the weeds, just make sure people's privacy is respected

Unit 3 Discussion

- ▶ What Federal and State laws address liability during dispensing operations?
- ▶ What 7 elements of information must be included on each label?
- ▶ When might the FDA issue an EUA for a medical product?
- ▶ How does HIPAA apply to dispensing operations?



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Unit 4:

Medical Dispensing

Objectives

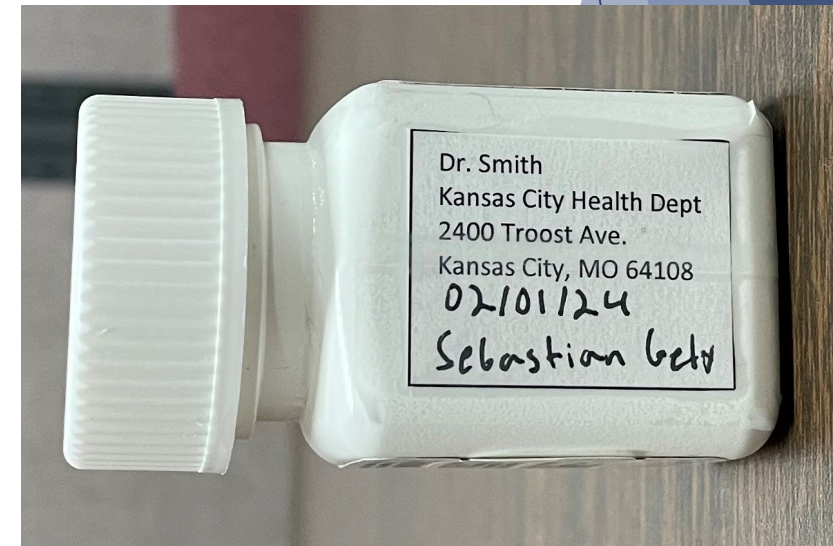
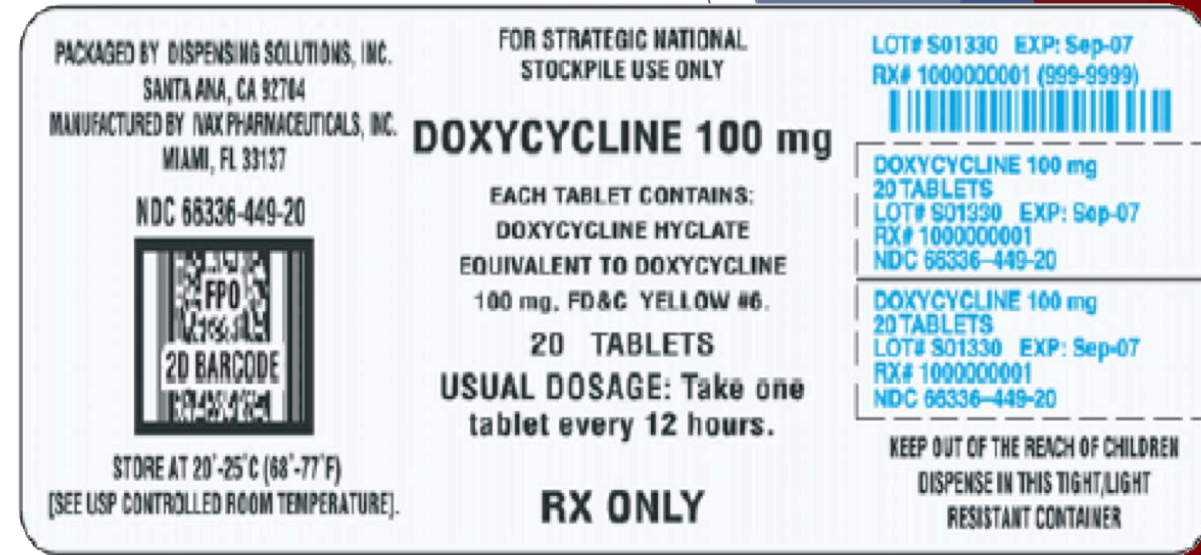
- ▶ Learn the 6 Rights of Medication Administration
- ▶ Screen patients and determine which and how much medication is appropriate for the individual by using provided algorithms
- ▶ Demonstrate how to safely dispense medications during mass prophylaxis operations
- ▶ How to properly educate patients

The Six RIGHTS of Medication Administration

- ▶ Right **Person**
 - ▶ Each name on the bottle
- ▶ Right **Time**
 - ▶ SNS oral medications are taken every 12 hours
- ▶ Right **Route**
 - ▶ By mouth
- ▶ Right **Dose**
 - ▶ Special considerations based on weight
- ▶ Right **Medication**
 - ▶ Use dispensing algorithm with Standing Orders
- ▶ Right **Documentation**
 - ▶ Medication Assessment Form/Dispensing Log

Right Person, Time, Route, Dose, and Medication

- ▶ How to read medication label:
 - ▶ Name of the medication
 - ▶ Dosage strength
 - ▶ Quantity of medication
 - ▶ Dosage frequency
 - ▶ Route of administration
 - ▶ Expiration date



EUI vs. EUA

- ▶ Earlier we discussed EUAs for new drugs or drugs with unapproved uses for treatment
- ▶ Along with EUAs there are documents called Emergency Use Instructions (EUI)
 - ▶ EUIs allow the CDC to inform people about certain uses of medical products in specific circumstances
 - ▶ This allows the use of medical products for purposes they're not generally intended for, with prior study and approval, without an EUA

EUIs: Provider vs. Recipient

- ▶ CDC provides two documents for EUIs: those for providers and those for recipients
 - ▶ In your handouts there are two examples of EUIs for providers; one for Doxy and one for Cipro during an Anthrax attack
- ▶ Provider EUIs
 - ▶ These EUIs are meant for providers to inform them on the specific uses of the medication
 - ▶ These have much more detailed instructions and information regarding the medications

Additional Information on Provider EUI

Table 1. Ciprofloxacin Oral Suspension

Weight in pounds (kilograms)	Dose* in milliliters (mL) 250 mg/5 mL strength	Dose* in milliliters (mL) 500 mg/5 mL strength	Number of 100 mL bottles needed for 10-day supply for one patient	
			250 mg/5 mL strength	500 mg/5 mL strength
0–7 lbs (0–3 kg)	1 mL (50 mg)	0.5 mL (50 mg)	ONE (1) Bottle	ONE (1) Bottle
8–14 lbs (4–6 kg)	2 mL (100 mg)	1 mL (100 mg)		
15–22 lbs (7–10 kg)	3 mL (150 mg)	1.5 mL (150 mg)		
23–29 lbs (11–13 kg)	4 mL (200 mg)	2 mL (200 mg)		
30–36 lbs (14–16 kg)	5 mL (250 mg)	2.5 mL (250 mg)		
37–44 lbs (17–20 kg)	6 mL (300 mg)	3 mL (300 mg)	TWO (2) Bottles	
45–51 lbs (21–23 kg)	7 mL (350 mg)	3.5 mL (350 mg)		
52–58 lbs (24–26 kg)	8 mL (400 mg)	4 mL (400 mg)		
59–66 lbs (27–30 kg)	9 mL (450 mg)	4.5 mL (450 mg)		
> 67 lbs (> 31 kg)	10 mL (500 mg)	5 mL (500 mg)		

Table 2. Doxycycline Oral Suspension

Weight in pounds (kilograms)	Dose in mL (based on 25 mg/5 mL concentration)	Number of 60 mL bottles (25 mg/5 mL concentration) needed for 10-day supply for one patient
0–5 lbs (0–2 kg)	1 mL (5mg)	ONE (1) Bottle
6–10 lbs (3–4 kg)	2 mL (10 mg)	
11–15 lbs (5–7 kg)	3 mL (15 mg)	
16–20 lbs (8–9 kg)	4 mL (20 mg)	TWO (2) Bottles
21–25 lbs (10–11 kg)	5 mL (25 mg)	
26–30 lbs (12–14 kg)	6 mL (30 mg)	

January 2017

Screeners Reference Card

- ▶ Receive Medication Assessment Form from patient
- ▶ Review form for completion and accuracy with patient
- ▶ Make dispensing decision
- ▶ Circle correct antibiotic to be dispensed
- ▶ Initial form next to circled antibiotic
- ▶ If anyone in the household is referred to Functional Needs, **STOP AND IMMEDIATELY REFER THE ENTIRE HOUSEHOLD** to Functional Needs for all dispensing
- ▶ Give patient the appropriate medication fact sheet(s)
- ▶ Instruct the patient to proceed to dispenser

Step 1

LIST ALL HOUSEHOLD MEMBERS FOR WHOM YOU ARE PICKING UP MEDICATIONS TODAY, INCLUDING YOURSELF

Step 2

FOR **EACH** HOUSEHOLD MEMBER LISTED BELOW, ANSWER **ALL** QUESTIONS.

Question 1

- Is this person allergic to doxycycline or other "cycline" drugs?
- Is this person pregnant?

Question 2

- Does this person have difficulty swallowing pills?
- Is this person both less than 90 pounds and less than 18 years of age?

Question 3

- Is this person allergic to Ciprofloxacin or "floxacin" drugs?
- Does this person have seizure disorder or epilepsy?
- Is this person taking Tizanidine (Zanaflex)?
- Does this person have renal (kidney) disease?

Question 4

- Does this person have difficulty swallowing pills?
- Is this person both less than 90 pounds and less than 18 years of age?

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Drug Assignment

D, C, X

D for Doxycycline
C for Ciprofloxacin
X for Do Not Dispense

Last name	First name	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	D, C, X	Lot Number

Step 3

Write in your address and telephone number to the right. If more than one, include all.

Telephone:

Address:

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Dispensing Site Name _____

Dispenser Signature _____ Date: _____

Instructions for Public Health Worker <i>(follow the instructions to the right for each individual)</i>	Q1	Q2	Q3	Q4	
	<p><u>NO</u>: Evaluate question 2</p> <p><u>YES</u>: Skip to question 3</p>	<p><u>NO</u>: Provide Doxycycline and STOP</p> <p><u>YES</u>: Provide Doxycycline and Emergency Preparation Instructions & STOP</p>	<p><u>NO</u>: Evaluate question 4</p> <p><u>YES</u>: Advise person seek medical consult</p>	<p><u>NO</u>: Provide Ciprofloxacin</p> <p><u>YES</u>: Advise person to seek medical consult</p>	

Question 1	Question 2	Question 3	Question 4	Antibiotic
No	No	X	X	Doxycycline (D)
No	Yes	X	X	Doxycycline (D) with Instructions
Yes	X	No	No	Ciprofloxacin (C)
Yes	X	Yes	X	Advise to seek medical consult (X)
Yes	X	No	Yes	Advise to seek medical consult (X)

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LIST ALL HOUSEHOLD MEMBERS FOR WHOM YOU ARE PICKING UP MEDICATIONS TODAY, INCLUDING YOURSELF

Step 2

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Drug Assignment

D, C, X

D for Doxycycline
C for Ciprofloxacin
X for Do Not Dispense

Last name

First name

If yes to **any**, write yes
If no to **all**, write no

If yes to **any**, write yes
If no to **all**, write no

If yes to **any**, write yes
If no to **all**, write no

If yes to **any**, write yes
If no to **all**, write no

D, C, X

Lot Number

HOH Last Name, First Name

Step 3

Write in your address and telephone number to the right. If more than one, include all.

Telephone:

Address:

Head of Household (HOH) Info is entered here

FOR PUBLIC HEALTH WORKER'S USE ONLY

Dispensing Site Name _____

Dispenser Signature _____ Date: _____

Step 1

LIST ALL HOUSEHOLD MEMBERS FOR WHOM YOU ARE PICKING UP MEDICATIONS TODAY, INCLUDING YOURSELF

Step 2

FOR **EACH** HOUSEHOLD MEMBER LISTED BELOW, ANSWER **ALL** QUESTIONS.

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Drug Assignment

D, C, X

D for Doxycycline
C for Ciprofloxacin
X for Do Not Dispense

Last name

First name

If yes to **any**, write yes
If no to **all**, write no

If yes to **any**, write yes
If no to **all**, write no

If yes to **any**, write yes
If no to **all**, write no

If yes to **any**, write yes
If no to **all**, write no

D, C, X

Lot Number

HOH Last Name, First Name

List All other Household Members Last Name, First Name

HOH must answer these questions for each person listed:
Answer 'Yes', 'No' or 'Don't Know'

Step 3

Write in your address and telephone number to the right. If more than one, include all.

Telephone:

Address:

Head of Household (HOH) Info is entered here

FOR PUBLIC HEALTH WORKER'S USE ONLY

Dispensing Site Name _____

Dispenser Signature _____ Date: _____

START HERE

Medication Assessment Form

Missouri Medical Countermeasures/Strategic National Stockpile Program

Name: Address: City, State, Zip: E-Mail: Phone:		Question 1 2 PARTS 1. Is this person <u>smaller than 76 pounds</u> ? 2. If YES, write in the weight in pounds. If NO, leave blank.	Question 2 Can this person <u>swallow pills</u> ?	Question 3 4 PARTS 1. Is this person <u>allergic to or should not take Cipro</u> (Ciprofloxacin), <u>Levaquin</u> (levofloxacin), or other floxacins antibiotic? <u>OR</u> 2. Does this person take tizanidine (<u>Zanaflex</u>)? <u>OR</u> 3. Does this person have a history of the muscle disease myasthenia gravis? 4. If answer to <u>any</u> question is YES, answer Yes below.	Question 4 Is this person <u>allergic to or should not take</u> doxycycline, tetracycline, or other "cycline" antibiotic?	Question 5 Is this person <u>pregnant</u> ?	Once you have received your medicine: <ul style="list-style-type: none"> Be sure to carefully read the fact sheet you have been given. Take the medicine exactly as prescribed unless your medical provider or a public health official tells you to stop. If you stop too soon, you could become sick. Take the medicine even if you feel well. If you do begin to feel sick with symptoms of the disease, it is important to get medical help right away. If you have questions, contact your medical provider or _____.
Step 1. Place your own name in the first line below. List all household members for whom you are picking up medicine below your name. Step 2. For each person listed, answer all 5 questions. Step 3. Each person should take the medicine provided exactly as instructed.							STAFF USE ONLY For persons who cannot take an adult dose or cannot swallow pills, use available options: Doxy <u>tablets</u> with <u>Crushing Instructions</u> , Doxy <u>Suspension</u> , or Cipro <u>Suspension</u> . Dose is based on person's weight. Mark the antibiotic provided; Affix label here
Last Name, First Name		Weight if less than 76 pounds?	Yes, No, Don't Know?	Yes, No, Don't Know?	Yes, No, Don't Know?	Yes, No, Don't Know?	
1. HOH Last Name, First Name							Doxy Tabs Cipro Tabs Doxy Tabs Crush Ins Doxy Susp Cipro Susp
2.							Doxy Tabs Cipro Tabs Doxy Tabs Crush Ins Doxy Susp Cipro Susp
3. List All other Household Members Last Name, First Name							Doxy Tabs Cipro Tabs Doxy Tabs Crush Ins Doxy Susp Cipro Susp
4.							Doxy Tabs Cipro Tabs Doxy Tabs Crush Ins Doxy Susp Cipro Susp
5.							Doxy Tabs Cipro Tabs Doxy Tabs Crush Ins Doxy Susp Cipro Susp
August 2016		Add totals under the columns					

Head of Household (HOH) Info is entered in this shaded box.

HOH must answer these questions for each person listed: Answer 'Yes', 'No' or 'Don't Know'

**Doxycycline Preferred With Ciprofloxacin Alternate
(Ciprofloxacin Preferred for Pregnant Women)**

1. Weight 76+ pounds				2. Able to Swallow Pills			
Yes		No		Yes		No	
3. Cannot Take Cipro	4. Cannot Take Doxy	5. Pregnant?	Dispense	3. Cannot Take Cipro	4. Cannot Take Doxy	5. Pregnant?	Dispense
No/DK	No/DK	No/DK	Doxy 100 mg Tablets	No/DK	No/DK	No/DK	Doxy 100 mg Tablets + Crushing Instructions
No/DK	No/DK	Yes	Cipro 500 mg Tablets	No/DK	No/DK	Yes	Doxy 100 mg Tablets + Crushing Instructions
Yes	No/DK	Any	Doxy 100 mg Tablets	Yes	No/DK	Any	Doxy 100 mg Tablets + Crushing Instructions
No/DK	Yes	Any	Cipro 500 mg Tablets	No/DK	Yes	Any	Refer
Yes	Yes	Any	Refer	Yes	Yes	Any	Refer

1. Weight 67-75 pounds				2. Able to Swallow Pills			
Yes		No		Yes		No	
3. Cannot Take Cipro	4. Cannot Take Doxy	5. Pregnant?	Dispense	3. Cannot Take Cipro	4. Cannot Take Doxy	5. Pregnant?	Dispense
No/DK	No/DK	No/DK	Doxy 100 mg Tablets + Crushing Instructions	No/DK	No/DK	No/DK	Doxy 100 mg Tablets + Crushing Instructions
No/DK	No/DK	Yes	Cipro 500 mg Tablets	No/DK	No/DK	Yes	Doxy 100 mg Tablets + Crushing Instructions
Yes	No/DK	Any	Doxy 100 mg Tablets + Crushing Instructions	Yes	No/DK	Any	Doxy 100 mg Tablets + Crushing Instructions
No/DK	Yes	Any	Cipro 500 mg Tablets	No/DK	Yes	Any	Refer
Yes	Yes	Any	Refer	Yes	Yes	Any	Refer

Note that in the tables, **Yes**, **No**, or **DK** (Don't Know) refer to the answers given to the questions on the Medication Assessment Form. For example, for "3. Cannot Take Cipro," a **No** answer means the person has indicated they do not have any of the reasons listed on the form for not taking ciprofloxacin, and thus they can be given this drug if indicated. On the other hand, a **Yes** answer means the person has indicated they do have one or more of the reasons listed on the form for not taking ciprofloxacin, and thus they should not be given this drug.

1. Weight 31-66 pounds				2. Able to Swallow Pills			
Yes		No		Yes		No	
3. Cannot Take Cipro	4. Cannot Take Doxy	5. Pregnant?	Dispense	3. Cannot Take Cipro	4. Cannot Take Doxy	5. Pregnant?	Dispense
No/DK	No/DK	NA	Doxy 100 mg Tablets + Crushing Instructions	No/DK	No/DK	NA	Doxy 100 mg Tablets + Crushing Instructions
Yes	No/DK	NA	Doxy 100 mg Tablets + Crushing Instructions	Yes	No/DK	NA	Doxy 100 mg Tablets + Crushing Instructions
No/DK	Yes	NA	Cipro Suspension*	No/DK	Yes	NA	Cipro Suspension*
Yes	Yes	NA	Refer	Yes	Yes	NA	Refer

1. Weight 0-30 pounds				2. Able to Swallow Pills			
Yes		No		Yes		No	
3. Cannot Take Cipro	4. Cannot Take Doxy	5. Pregnant?	Dispense	3. Cannot Take Cipro	4. Cannot Take Doxy	5. Pregnant?	Dispense
No/DK	No/DK	NA	Doxy Suspension**	No/DK	No/DK	NA	Doxy Suspension**
Yes	No/DK	NA	Doxy Suspension**	Yes	No/DK	NA	Doxy Suspension**
No/DK	Yes	NA	Cipro Suspension*	No/DK	Yes	NA	Cipro Suspension*
Yes	Yes	NA	Refer	Yes	Yes	NA	Refer

DK = Don't Know, **NA** = Not Applicable

Note that the crushing instructions for doxycycline tablets contain a dosage chart based on weight.

*Provide Cipro Suspension according to the instructions in Table 1, below. Ensure the dose, based on Table 1, is written on the bottle AND marked with a line on the graduated teaspoon or oral syringe provided. If Cipro Suspension is not available, refer.

**Provide Doxy Suspension according to the instructions in Table 2, below. Ensure the dose, based on Table 2, is written on the bottle AND marked with a line on the graduated teaspoon or oral syringe provided. If Doxy Suspension is not available and the individual can take ciprofloxacin, then provide Cipro Suspension according to the instructions in Table 1, below. Ensure the dose of Cipro, based on Table 1, is written on the bottle AND marked with a line on the graduated teaspoon or oral syringe provided. If neither Doxy Suspension or Cipro Suspension is available and the individual can take doxycycline, then provide Doxy 100 mg Tablets + Crushing Instructions.

Table 1. Ciprofloxacin Oral Suspension

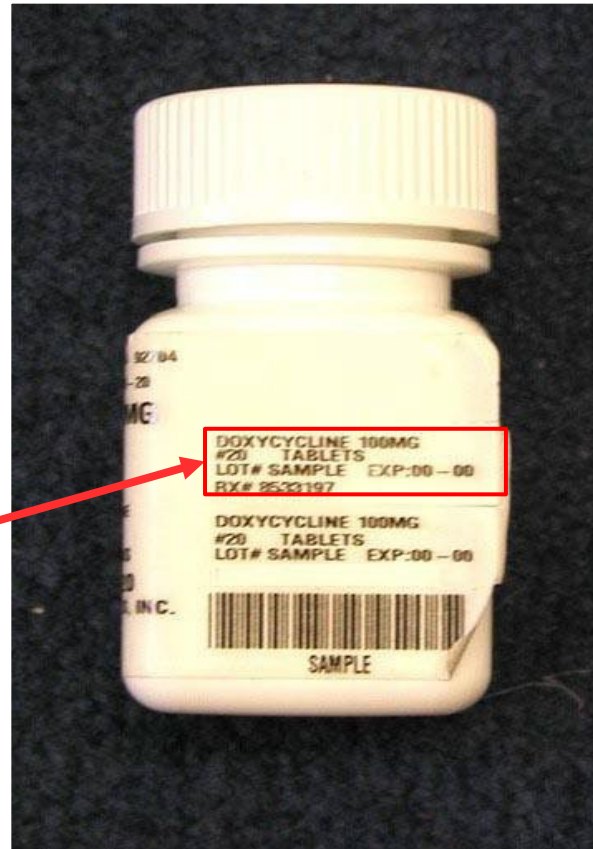
Weight in pounds (kilograms)	Dose* in milliliters (mL) 250 mg/5 mL strength	Dose* in milliliters (mL) 500 mg/5 mL strength	Number of 100 mL bottles needed for 10-day supply for one patient	
			250 mg/5 mL strength	500 mg/5 mL strength
0–7 lbs (0–3 kg)	1 mL (50 mg)	0.5 mL (50 mg)	ONE (1) Bottle	ONE (1) Bottle
8–14 lbs (4–6 kg)	2 mL (100 mg)	1 mL (100 mg)		
15–22 lbs (7–10 kg)	3 mL (150 mg)	1.5 mL (150 mg)		
23–29 lbs (11–13 kg)	4 mL (200 mg)	2 mL (200 mg)		
30–36 lbs (14–16 kg)	5 mL (250 mg)	2.5 mL (250 mg)		
37–44 lbs (17–20 kg)	6 mL (300 mg)	3 mL (300 mg)		
45–51 lbs (21–23 kg)	7 mL (350 mg)	3.5 mL (350 mg)	TWO (2) Bottles	ONE (1) Bottle
52–58 lbs (24–26 kg)	8 mL (400 mg)	4 mL (400 mg)		
59–66 lbs (27–30 kg)	9 mL (450 mg)	4.5 mL (450 mg)		
> 67 lbs (> 31 kg)	10 mL (500 mg)	5 mL (500 mg)		

Table 2. Doxycycline Oral Suspension

Weight in pounds (kilograms)	Dose in mL (based on 25 mg/5 mL concentration)	Number of 60 mL bottles (25 mg/5 mL concentration) needed for 10-day supply for one patient
0–5 lbs (0–2 kg)	1 mL (5mg)	ONE (1) Bottle
6–10 lbs (3–4 kg)	2 mL (10 mg)	
11–15 lbs (5–7 kg)	3 mL (15 mg)	
16–20 lbs (8–9 kg)	4 mL (20 mg)	TWO (2) Bottles
21–25 lbs (10–11 kg)	5 mL (25 mg)	
26–30 lbs (12–14 kg)	6 mL (30 mg)	

Documentation

- ▶ All medications dispensed should have documentation in two places:
 - ▶ Medication Assessment Form/Dispensing Log
 - ▶ Medication Bottle



Exercise

Step 1		Step 2				FOR PUBLIC HEALTH WORKER'S USE ONLY	
LIST ALL HOUSEHOLD MEMBERS FOR WHOM YOU ARE PICKING UP MEDICATIONS TODAY, INCLUDING YOURSELF		FOR <u>EACH</u> HOUSEHOLD MEMBER LISTED BELOW, ANSWER <u>ALL</u> QUESTIONS.					
		Question 1	Question 2	Question 3	Question 4		
		<ul style="list-style-type: none"> Is this person allergic to doxycycline or other "cycline" drugs? Is this person pregnant? 	<ul style="list-style-type: none"> Does this person have difficulty swallowing pills? Is this person both less than 90 pounds and less than 18 years of age? 	<ul style="list-style-type: none"> Is this person allergic to Ciprofloxacin or "floxacin" drugs? Does this person have seizure disorder or epilepsy? Is this person taking Tizanidine (Zanaflex)? Does this person have renal (kidney) disease? 	<ul style="list-style-type: none"> Does this person have difficulty swallowing pills? Is this person both less than 90 pounds and less than 18 years of age? 		
Last name	First name	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	D, C, X	Lot Number
Soprano	Anthony						
Soprano	Carmella						
Soprano	Meadow						
Soprano	Anthony Jr.						
Baccalieri	Robert						

Step 3 Write in your address and telephone number to the right. If more than one, include all.	Telephone: 573-298-1191	Address: 14 Aspen Dr. Columbia, MO 65203
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FOR PUBLIC HEALTH WORKER'S USE ONLY	Dispensing Site Name _____	
	Dispenser Signature _____	Date: _____

Exercise

Step 1		Step 2				FOR PUBLIC HEALTH WORKER'S USE ONLY	
LIST ALL HOUSEHOLD MEMBERS FOR WHOM YOU ARE PICKING UP MEDICATIONS TODAY, INCLUDING YOURSELF		FOR <u>EACH</u> HOUSEHOLD MEMBER LISTED BELOW, ANSWER <u>ALL</u> QUESTIONS.					
		Question 1	Question 2	Question 3	Question 4		
		<ul style="list-style-type: none"> Is this person allergic to doxycycline or other "cycline" drugs? Is this person pregnant? 	<ul style="list-style-type: none"> Does this person have difficulty swallowing pills? Is this person both less than 90 pounds and less than 18 years of age? 	<ul style="list-style-type: none"> Is this person allergic to Ciprofloxacin or "floxacin" drugs? Does this person have seizure disorder or epilepsy? Is this person taking Tizanidine (Zanaflex)? Does this person have renal (kidney) disease? 	<ul style="list-style-type: none"> Does this person have difficulty swallowing pills? Is this person both less than 90 pounds and less than 18 years of age? 		
Last name	First name	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	D, C, X	Lot Number
Soprano	Anthony	NO	NO				
Soprano	Carmella	Yes		NO	Yes		
Soprano	Meadow	NO	Yes				
Soprano	Anthony Jr.	Yes		Yes			
Baccalieri	Robert	Yes		NO	NO		
Step 3		Telephone:		Address:			
Write in your address and telephone number to the right. If more than one, include all.		573-298-1191		14 Aspen Dr. Columbin, MO 65201			
FOR PUBLIC HEALTH WORKER'S USE ONLY		Dispensing Site Name _____					
		Dispenser Signature _____ Date: _____					

Exercise

Step 1 LIST ALL HOUSEHOLD MEMBERS FOR WHOM YOU ARE PICKING UP MEDICATIONS TODAY, INCLUDING YOURSELF		Step 2 FOR <u>EACH</u> HOUSEHOLD MEMBER LISTED BELOW, ANSWER <u>ALL</u> QUESTIONS.				FOR PUBLIC HEALTH WORKER'S USE ONLY Drug Assignment <u>D, C, X</u> D for Doxycycline C for Ciprofloxacin X for Do Not Dispense	
		<u>Question 1</u> • Is this person allergic to doxycycline or other "cycline" drugs? • Is this person pregnant?	<u>Question 2</u> • Does this person have difficulty swallowing pills? • Is this person both less than 90 pounds and less than 18 years of age?	<u>Question 3</u> • Is this person allergic to Ciprofloxacin or "floxacin" drugs? • Does this person have seizure disorder or epilepsy? • Is this person taking Tizanidine (Zanaflex)? • Does this person have renal (kidney) disease?	<u>Question 4</u> • Does this person have difficulty swallowing pills? • Is this person both less than 90 pounds and less than 18 years of age?		
Last name	First name	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	If yes to <u>any</u> , write yes If no to <u>all</u> , write no	D, C, X	Lot Number
Soprano	Anthony	No	NO			0	DOXYCYCLINE 100MG 20 TABLETS LOT# 01234 EXP: 12-22 RX# XXXX
Soprano	Carmella	Yes		No	Yes	X	
Soprano	Meadow	No	Yes			D(C)	DOXYCYCLINE 100MG 20 TABLETS LOT# 01234 EXP: 12-22 NDC - 66336 - 449 - 20
Soprano	Anthony Jr.	Yes		Yes		X	
Baccalieri	Robert	Yes		No	No	C	CIPROFLOXACIN HCl 500MG 20 TABLETS LOT# 01234 EXP: 12-22 NDC 66336 - 903 - 20
Step 3 Write in your address and telephone number to the right. If more than one, include all.		Telephone: 573-298-1191		Address: 14 Aspen Dr. Columbin, MO 65203			
FOR PUBLIC HEALTH WORKER'S USE ONLY		Dispensing Site Name <u>KCHD</u> Dispenser Signature <u>Sebastian Gely</u> Date: <u>01/31/24</u>					

Patient Education: EUIs

- ▶ These should be given to recipients as they are receiving their medications
- ▶ Recipient EUIs are written with easier to understand instructions using less technical language than the Provider EUIs
- ▶ These are not a substitute for Vaccine Information Statements (VIS)

Special Information in EUIs

**In an Emergency:
How to Prepare
Doxycycline Hyclate
for Children and Adults
Who Cannot Swallow Pills**

During a public health emergency, you might need to prepare emergency doses of doxycycline for children and adults who cannot swallow pills. This pamphlet shows you how to mix doxycycline hyclate 100 mg tablets with food or drink.

Follow the instructions below to prepare and give your child the **right amount** of medicine **every 12 hours** (once in the morning and once at night) **each day**, as long as directed. Use the same directions for adults who cannot swallow pills.

A Get the supplies you need.

You will need these items to make doses of doxycycline for children and adults who cannot swallow pills:

- 1 doxycycline hyclate **tablet** (100 mg)
- 1 metal teaspoon
- 1 oral syringe or medicine spoon (if available)
- 2 small bowls
- small amount of drinking water (4 teaspoons or 20 mL)
- 1 of these foods or drinks to make the crushed doxycycline taste better*:
 - milk, including breast milk and formula for infants
 - chocolate milk
 - chocolate pudding
 - apple juice mixed with 2 to 4 teaspoons of sugar

*Doxycycline works just as well whether you take it with or without food or milk.

A supplemental video of these instructions is available by searching "doxycycline crushing instructions" on www.cdc.gov

Doxycycline EUI Crushing Instructions (originally issued 03/28/2016; revised 08/18/2017)

B Soak the tablet in water and crush it.

1. Put 1 doxycycline hyclate tablet in a small bowl.
2. Add 4 teaspoons (20 mL) of water to the same bowl.
3. Let the tablet **soak** in the water for at least **10 minutes** to soften it.
4. **Crush** the tablet with the back of the metal spoon until you can't see any pieces of the tablet in the water.
5. Stir the tablet and water to mix it well.

You have now made the doxycycline and water mixture.

C Measure the right amount of doxycycline.

1. Find your child's **weight** on the chart below. *Weight is better, but if you don't know how much your child weighs, find your child's **age** on the chart.*
2. Follow the row of your child's weight or age across to the column "**Amount of Doxycycline & Water Mixture to Measure**."

Weight	Age	Amount of Doxycycline & Water Mixture to Measure*
12 pounds or less	Less than 1 month	½ teaspoon (2.5 mL) 1
13 to 25 pounds	1 to 11 months	1 teaspoon (5 mL) 2
26 to 50 pounds	1 to 5 years	2 teaspoons (10 mL) 4
51 to 75 pounds	6 to 8 years	3 teaspoons (15 mL) 6
76 pounds or more (Adult Dose)	9 years or older	4 teaspoons (20 mL) 8

*Weight-range dosing based on 2.2 mg/kg derived dose calculation.

3. **Measure** the amount of doxycycline and water mixture for your child's weight or age from the first bowl. *For a ½ teaspoon dose, fill the teaspoon halfway or use an oral syringe (if available). It is better to give a little more of the medicine than not enough.*
4. Place this amount into the **second bowl**. This is **one dose** that should be mixed with food or drink.

For children weighing 76 pounds or more and adults who cannot swallow pills, **use all of the doxycycline and water mixture in the first bowl (4 teaspoons); the entire contents of the first bowl makes one dose** that should be mixed with food or drink.

Doxycycline EUI Crushing Instructions (originally issued 03/28/2016; revised 08/18/2017)

https://www.cdc.gov anthrax/prevention/doxycycline-preparation-instructions.html?CDC_AAref_Val=https://www.cdc.gov anthrax/public-health/doxy-crushing-instruction-pamphlet.html -

Right Dose Doxy EUI for Children & Adults Who Cannot Swallow Pills

D Mix the dose with food or drink.



1. Mix the **dose** (measured amount of doxycycline and water mixture) in the second bowl with **3 teaspoons** of one of the following:

- Milk, including breast milk and formula for infants
- Chocolate milk
- Chocolate pudding
- OR
- Apple juice mixed with 2 to 4 teaspoons of sugar

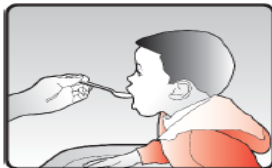


You now have one dose, mixed with food or drink.

2. Stir well before giving it to your child.

E Give the dose.

1. Give your child **all** of the doxycycline, water and food mixture from the second bowl. Make sure your child swallows all of it. This is one dose.
2. Do this once **every 12 hours** (once in the morning AND once at night) **each day** for as long as directed.

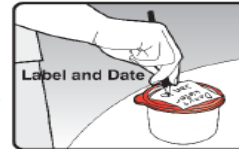


What should you do with any leftover doxycycline and water mixture remaining in the first bowl?

Throw it away if your child weighs 51 pounds or more (or is 6 years or older). You do NOT have enough left over to make another dose.

Keep it if your child weighs 50 pounds or less (or is 5 years or younger). You will have enough left over to make another dose.

- **Store** the **doxycycline and water mixture** in a covered bowl or cup at room temperature (between 68–77°F or 20–25°C) for up to 24 hours.
- **Write** the date, time and container contents on a label.
- **Keep** the mixture in a safe place, out of the reach of children or pets.
- **Throw away** any unused mixture after 24 hours and make a new doxycycline and water mixture for the next dose.



What should you know about side effects?


- Do not take doxycycline if you are allergic to an ingredient in doxycycline hyclate or any tetracycline antibiotics.
- Get emergency help if you have any signs of an allergic reaction, including hives, difficulty breathing or swelling of your face, lips, tongue or throat.
- Doxycycline may cause diarrhea, skin reaction to the sun, loss of appetite, nausea and vomiting. Refer to "Anthrax Emergency: How to Take Doxycycline to Prevent Anthrax" instructions for more information on possible side effects.
- Report any reaction to doxycycline to MedWatch at www.fda.gov/medwatch or 1-800-FDA-1088.



Patient Education: Vaccine Information Statement (VIS)

- ▶ Vaccine Information Statements (VIS) are required by US Law
- ▶ A paper copy **MUST BE PROVIDED** prior to vaccination
- ▶ They are provided for patient education

VACCINE INFORMATION STATEMENT	
Influenza (Flu) Vaccine (Inactivated or Recombinant): What you need to know	
1 Why get vaccinated?	<p>There is no live flu virus in flu shots. They cannot cause the flu.</p> <p>There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.</p> <p>Flu vaccine cannot prevent:</p> <ul style="list-style-type: none">• flu that is caused by a virus not covered by the vaccine, or• illnesses that look like flu but are not. <p>It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.</p>
2 Inactivated and recombinant flu vaccines	<p>A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.</p> <p>Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.</p>
3 Some people should not get this vaccine	<p>Tell the person who is giving you the vaccine:</p> <ul style="list-style-type: none">• If you have any severe, life-threatening allergies. If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.• If you ever had Guillain-Barré Syndrome (also called GBS). Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.• If you are not feeling well. It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

4 Risks of a vaccine reaction	<p>With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.</p> <p>Most people who get a flu shot do not have any problems with it.</p> <p>Minor problems following a flu shot include:</p> <ul style="list-style-type: none">• soreness, redness, or swelling where the shot was given• hoarseness• sore, red or itchy eyes• cough• fever• aches• headache• itching• fatigue <p>If these problems occur, they usually begin soon after the shot and last 1 or 2 days.</p> <p>More serious problems following a flu shot can include the following:</p> <ul style="list-style-type: none">• There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.• Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure. <p>Problems that could happen after any injected vaccine:</p> <ul style="list-style-type: none">• People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.• Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.• Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination. <p>As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.</p> <p>The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/</p>	5 What if there is a serious reaction?
	<p>What should I look for?</p> <ul style="list-style-type: none">• Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior. <p>Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.</p> <p>What should I do?</p> <ul style="list-style-type: none">• If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.• Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967. <p>VAERS does not give medical advice.</p>	
	6 The National Vaccine Injury Compensation Program	
	<p>The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.</p> <p>Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.</p>	
	7 How can I learn more?	
	<ul style="list-style-type: none">• Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.• Call your local or state health department.• Contact the Centers for Disease Control and Prevention (CDC):<ul style="list-style-type: none">- Call 1-800-232-4636 (1-800-CDC-INFO) or- Visit CDC's website at www.cdc.gov/flu <p>Vaccine Information Statement Inactivated Influenza Vaccine</p> <p>08/07/2015</p> <p>42 U.S.C. § 300aa-26</p> 	

Post Dispensing Instructions

- ▶ Inform recipients they need to take first dose immediately
- ▶ Report any adverse effects to the State Hotline (800-392-0272)
- ▶ Inform recipients to watch media for further information
- ▶ Direct Head of Household to exit the POD

Unaccompanied Minors

- ▶ There are no state regulations pertaining to dispensing to unaccompanied minors
 - ▶ Local jurisdictions will need to decide their policies when it comes to unaccompanied minors
 - ▶ Unaccompanied minors can be the head of household if the situation dictates it



MISSOURI DEPARTMENT OF
**HEALTH &
SENIOR SERVICES**



Unit 4:

Vaccine Clinics

Vaccine Administration Information




- ▶ PODs by their very nature are typically going to be at offsite locations
- ▶ This requires special preparation and planning
 - ▶ This includes planning for things like:
 - ▶ Cold Chain Management
 - ▶ Security
 - ▶ Ancillary supplies
 - ▶ Waste Disposal

CHECKLIST
of
Best Practices
FOR Vaccination Clinics Held at
Satellite, Temporary, or Off-Site Locations

This checklist is a step-by-step guide to help clinic coordinators/supervisors overseeing vaccination clinics held at satellite, temporary, or off-site locations follow Centers for Disease Control and Prevention (CDC) guidelines and best practices for vaccine shipment, transport, storage, handling, preparation, administration, and documentation. These CDC guidelines and best practices are essential for patient safety and vaccine effectiveness. This checklist should be used in any non-traditional vaccination clinic settings, such as workplaces, community centers, schools, makeshift clinics in remote areas, and medical facilities when vaccination occurs in the public areas or classrooms. Temporary clinics also include mass vaccination events, walk-through, curbside, and drive-through clinics, and vaccination clinics held during pandemic preparedness exercises. A clinic coordinator/supervisor at the site should complete, sign, and date this checklist EACH TIME a vaccination clinic is held. To meet accountability and quality assurance standards, all signed checklists should be kept on file by the company that provided clinic staffing.

This document also contains sections, marked in red, that outline best practices for vaccination during the COVID-19 pandemic. For continued up-to-date guidance, please visit www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html.

INSTRUCTIONS

1. A staff member who will be at the vaccination clinic should be designated as the clinic coordinator/supervisor. This person will be responsible for completing the steps below and will be referred to as "you" in these instructions.
2. Review this checklist during the planning stage of the vaccination clinic—well in advance of the date(s) when the clinic will be held. This checklist includes sections to be completed before, during, and after the clinic.
3. Critical guidelines for patient safety and vaccine effectiveness are identified by the stop sign icon: . If you check "NO" in ONE OR MORE answer boxes that contain a , DO NOT move forward with the clinic. Follow your organization's protocols and/or contact your state or local health department for guidance BEFORE proceeding with the clinic. Do not administer any vaccine until you have confirmed you can move forward with the clinic.
4. Contact your organization and/or health department if you have any concerns about whether vaccine was transported, stored, handled, or administered correctly, whether patients' personal information was protected appropriately, or other responses that you have marked as "NO" in rows that do not have the .
5. This checklist should be used in conjunction with CDC's Vaccine Storage and Handling Toolkit: www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf. For information about specific vaccines, consult the vaccine manufacturer's package insert.
6. This checklist applies ONLY to vaccines stored at REFRIGERATED temperatures (i.e., between 2–8° Celsius or 36–46° Fahrenheit).
7. Sign and date the checklist upon completion of the clinic or completion of your shift (whichever comes first). (If more than one clinic coordinator/supervisor is responsible for different aspects of the clinic, you should complete only the section(s) for which you were responsible.)
8. Attach the staff sign-in sheet (with shift times and date) to the checklist (or checklists if more than one clinic supervisor is overseeing different shifts) and submit the checklist(s) to your organization to be kept on file for accountability.

Name and credentials of clinic coordinator/supervisor: _____

Name of facility where clinic was held: _____

Address where clinic was held (street, city, state): _____


Time and date of vaccination clinic shift (the portion you oversee): _____

Time (AM/PM) _____ Date (MM/DD/YYYY) _____

Time and date when form was completed: _____

Time (AM/PM) _____ Date (MM/DD/YYYY) _____

Signature of clinic coordinator/supervisor: _____

 U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

This document was created by the Influenza Work Group of the National Adult and Influenza Immunization Summit.
Version 9 (Updated August 18, 2020)

Vaccine Administration Information

- ▶ There are additional tools available to help with your planning
 - ▶ Handout 18 details the ten principles for holding a safe vaccination clinic
 - ▶ Handout 19 details specific supplies needed

Ten Principles for Holding Safe Vaccination Clinics at Satellite, Temporary, or Off-Site Locations

During All Stages (Pre-Clinic, During the Clinic, and Post-Clinic)

1. Keep vaccines at the correct temperature at all times using proper procedures for vaccine transport, handling and storage. Document temperature monitoring at appropriate intervals during all stages. For further guidance: www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf

Pre-Clinic

2. Have vaccine shipped directly to the site. If direct shipment is not possible, transport vaccine using correct storage and handling guidelines.
3. Train staff to perform CPR and treat medical emergencies, including anaphylaxis. Ensure supplies are on site, including an emergency medical kit and infection control supplies, as well as enough Vaccine Information Statements (VISs).

During the Clinic

4. Always check for medical allergies. Provide VISs for anyone.
5. Follow manufacturers' instructions for storage and handling (e.g., more than one dose).
6. Follow manufacturers' instructions for reconstitution and use.
7. Only use vaccines that are unexpired and prepared using aseptic technique.
8. Follow safe handling of needles and syringes for every injection.
9. Document every vaccination.

Post-Clinic

10. Keep patient information secure. Use the Immunization Information System (IIS), if available.
- For further guidance, refer to www.izsummitpartners.org



▶ This

YOU CALL THE SHOTS

Satellite, Temporary, and Off-Site Vaccination Clinic Supply Checklist

Below are supplies that may be needed to conduct a satellite, temporary, or off-site vaccination clinic. The list may not be comprehensive. Your [state or local public health immunization program](#) may also have a checklist.

For large-scale clinics held at large facilities, such as stadiums and arenas, or over multiple days, additional supplies will be needed. Contact your state or local public health preparedness program and work with the clinic medical director for additional guidance and assistance.

Quantity of supplies needed will vary significantly between smaller, one-day clinics held in schools, churches, or pharmacies and large-scale clinics held in arenas or held over multiple days.

VACCINES

Refrigerated vaccines

Select the vaccine(s) that will be offered at the clinic.

- | | |
|---|--|
| <input type="checkbox"/> Diphtheria, tetanus, and pertussis (DTaP) | <input type="checkbox"/> Measles, mumps, rubella* (MMR) |
| <input type="checkbox"/> DTaP-HepB-IPV (Pediarix) | <input type="checkbox"/> Meningococcal ACWY* (MenACWY) |
| <input type="checkbox"/> DTaP-IPV/Hib* (Pentacel) | <input type="checkbox"/> Meningococcal B (MenB) |
| <input type="checkbox"/> DTaP-IPV (Kinrix, Quadracel) | <input type="checkbox"/> Pneumococcal conjugate (PCV13) |
| <input type="checkbox"/> Haemophilus influenzae type b* (Hib) | <input type="checkbox"/> Pneumococcal polysaccharide (PPSV23) |
| <input type="checkbox"/> Hepatitis A (HepA) | <input type="checkbox"/> Polio, inactivated (IPV) |
| <input type="checkbox"/> Hepatitis B (HepB) | <input type="checkbox"/> Rotavirus* (RV) |
| <input type="checkbox"/> HepA-HepB (Twintrix) | <input type="checkbox"/> Tetanus-diphtheria, adult (Td) |
| <input type="checkbox"/> Human papillomavirus (vHPV) | <input type="checkbox"/> Tetanus, diphtheria, and pertussis (Tdap) |
| <input type="checkbox"/> Influenza, injectable (IV) (in season) | <input type="checkbox"/> Zoster, recombinant (RZV, Shingrix*) |
| <input type="checkbox"/> Influenza, live attenuated intranasal (LAIV) (in season) | |

Frozen vaccines

(Frozen vaccines may only be administered at satellite, temporary, and off-site clinics if they can be safely shipped to and monitored at the site. They should never be transported from one location to another.)

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Measles, mumps, rubella, varicella* (MMRV, ProQuad) | <input type="checkbox"/> Varicella* |
|--|-------------------------------------|

*Offices for ACWY, Hib, MMR, MenB, Pertacel, Rotarix, and Shingrix come packaged in the same container as the hepatitis component. Offsets for MMR, MMRV, and varicella come from the manufacturer packaged with the vaccine in separate containers.

CLINICAL SUPPLIES

Administration supplies

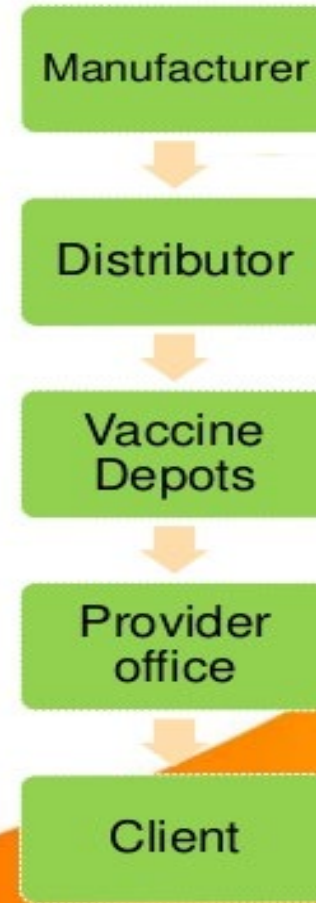
- | | |
|---|--|
| <input type="checkbox"/> Adhesive bandages | <input type="checkbox"/> Sterile alcohol prep pads |
| <input type="checkbox"/> Appropriate needles (length, gauge) for the route of administration (Subcut, IM) and the expected patient population | <input type="checkbox"/> Syringes (1 or 3 cc) |



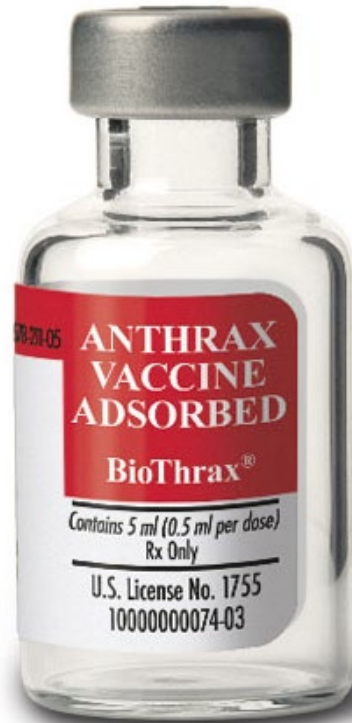
Vaccine Cold Chain Management

Cold Chain

The ‘cold chain’ is the system of transporting and storing vaccines at recommended temperature from the point of manufacture to the point of use.



Vaccine Storage and Handling



- ▶ Vaccines must be stored per manufactures' instructions
- ▶ Influenza and Anthrax vaccine must be kept at 36-46 F (2-8 C) at all times

What You Need to Know About Vaccine Storage Equipment: Refrigerators, Freezers, and Thermometers

PRESENTED BY



Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME _____

DATE OF BIRTH _____
month / day / year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a parent, brother, or sister with an immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had a seizure or a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever felt dizzy or faint before, during, or after a shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you anxious about getting a shot today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.



FOR PROFESSIONALS www.immunize.org / FOR THE PUBLIC www.vaccineinformation.org

www.immunize.org/catg.d/p4065.pdf
Item #P4065 (11/6/2023)



Patient Screening

- ▶ Ask if the patient has:
 - ▶ Allergies
 - ▶ Medical Conditions
 - ▶ Pregnancy
 - ▶ Previous Vaccines
 - ▶ Illness

Patient Education

- ▶ DO NOT FORGET THE Vaccine Information Statements (VIS), they are required by US Law

VACCINE INFORMATION STATEMENT	
Influenza (Flu) Vaccine (Inactivated or Recombinant): What you need to know	
1 Why get vaccinated?	<p>Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.</p> <p>Flu is caused by influenza viruses, and it spreads mainly by coughing, sneezing, and close contact.</p> <p>Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:</p> <ul style="list-style-type: none">• fever/chills• sore throat• muscle aches• fatigue• cough• headache• runny or stuffy nose <p>Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.</p> <p>Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.</p> <p>Each year thousands of people in the United States die from flu, and many more are hospitalized.</p> <p>Flu vaccine can:</p> <ul style="list-style-type: none">• keep you from getting flu,• make flu less severe if you do get it, and• keep you from spreading flu to your family and other people.
2 Inactivated and recombinant flu vaccines	<p>A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.</p> <p>Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.</p>
3 Some people should not get this vaccine	<p>There is no live flu virus in flu shots. They cannot cause the flu.</p> <p>There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.</p> <p>Flu vaccine cannot prevent:</p> <ul style="list-style-type: none">• flu that is caused by a virus not covered by the vaccine, or• illnesses that look like flu but are not. <p>It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.</p> <p>Tell the person who is giving you the vaccine:</p> <ul style="list-style-type: none">• If you have any severe, life-threatening allergies. If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.• If you ever had Guillain-Barré Syndrome (also called GBS). Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.• If you are not feeling well. It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

4 Risks of a vaccine reaction	<p>With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.</p> <p>Most people who get a flu shot do not have any problems with it.</p> <p>Minor problems following a flu shot include:</p> <ul style="list-style-type: none">• soreness, redness, or swelling where the shot was given• hoarseness• sore, red or itchy eyes• cough• fever• aches• headache• itching• fatigue <p>If these problems occur, they usually begin soon after the shot and last 1 or 2 days.</p> <p>More serious problems following a flu shot can include the following:</p> <ul style="list-style-type: none">• There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.• Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTap vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure. <p>Problems that could happen after any injected vaccine:</p> <ul style="list-style-type: none">• People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.• Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.• Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination. <p>As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.</p> <p>The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/</p>	5 What if there is a serious reaction? <p>What should I look for?</p> <ul style="list-style-type: none">• Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior. <p>Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.</p> <p>What should I do?</p> <ul style="list-style-type: none">• If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.• Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967. <p><i>VAERS does not give medical advice.</i></p>
6 The National Vaccine Injury Compensation Program	<p>The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.</p> <p>Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.</p>	
7 How can I learn more?	<ul style="list-style-type: none">• Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.• Call your local or state health department.• Contact the Centers for Disease Control and Prevention (CDC):<ul style="list-style-type: none">- Call 1-800-232-4636 (1-800-CDC-INFO) or- Visit CDC's website at www.cdc.gov/flu	

Vaccine Information Statement
Inactivated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Official Use Only

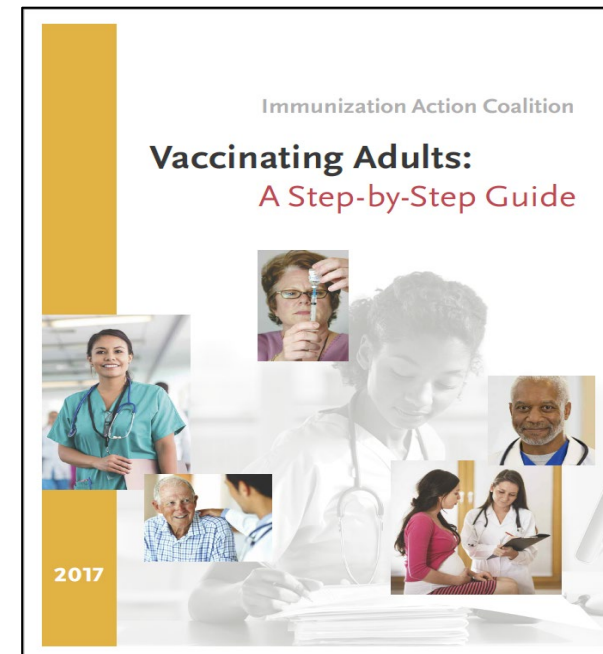
Vaccine Administration Documentation

STATE OF MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES IMMUNIZATION CONSENT AND HISTORY										CLINIC IDENTIFICATION	
LAST NAME		FIRST NAME		MI	DATE OF BIRTH		SEX	PARENT/GUARDIAN FULL NAME			
STREET ADDRESS		CITY		STATE	ZIP CODE		TELEPHONE NO.				
RACE (SELECT ALL THAT APPLY)											
<input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White											
ETHNICITY											
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino											
I have been given copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.											
VACCINE AND ROUTE (CIRCLE TYPE GIVEN WHERE APPLICABLE)	VISIT NO. & M/D/Y GIVEN	INJECTION SITE	VACCINE MANUFACTURER/ LOT NUMBER	VACCINE EXP. DATE	VIS REVISION DATE	DATE VIS GIVEN	SIGNATURE OF VACCINATOR	PATIENT OR PARENT/GUARDIAN CONSENT			
Hepatitis B								VISIT #1	DATE		
Hep B	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Diphtheria, Tetanus, Pertussis								VISIT #2	DATE		
DTap DTP DT IM								SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Haemophilus influenzae type b								VISIT #3	DATE		
Hib	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Polio								VISIT #4	DATE		
Polio SQ IM								SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Pneumococcal								VISIT #5	DATE		
PCV 13	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
COMMENTS											
MO 580-2023 (5-19) PAGE 1 OF 2 BUMP-9M											

IMMUNIZATION CONSENT AND HISTORY (CONTINUED)										PATIENT NAME	
VACCINE AND ROUTE (CIRCLE TYPE GIVEN WHERE APPLICABLE)	VISIT NO. & M/D/Y GIVEN	INJECTION SITE	VACCINE MANUFACTURER/ LOT NUMBER	VACCINE EXP. DATE	VIS REVISION DATE	DATE VIS GIVEN	SIGNATURE OF VACCINATOR	PATIENT OR PARENT/GUARDIAN CONSENT			
Pneumococcal polysaccharide PPSV 23 SQ IM								VISIT #5	DATE		
Measles, Mumps, Rubella MMR SQ								SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Varicella								VISIT #6	DATE		
Varicella SQ								SIGNATURE			
Rotavirus								ELIGIBILITY STATUS			
RV1	Oral							<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
RV5	Oral							VISIT #7	DATE		
Hepatitis A								SIGNATURE			
Hep A	IM							ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Human papilloma-virus								VISIT #8	DATE		
HPV	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Meningococcal								VISIT #9	DATE		
MenACWY	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Meningococcal B								VISIT #10	DATE		
MenB	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Tetanus, Diphtheria, Pertussis (7 years old and above)								VISIT #11	DATE		
Tdap	IM							SIGNATURE			
Td	IM							ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Influenza								VISIT #12	DATE		
IV (inactive)	IM							SIGNATURE			
RIV (recombinant)	IM							ELIGIBILITY STATUS			
LAIV (live attenuated intranasal)	IN							<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Zoster (Shingles)								VISIT #13	DATE		
RVZ (recombinant)	IM							SIGNATURE			
ZVL (live)	SQ							ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Other								VISIT #14	DATE		
Other								SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
COMMENTS											
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Resources

- ▶ Information on medication dispensing and vaccine administration are available on the Resource Handout and Include:
 - ▶ Centers for Disease Control and Prevention
 - ▶ Immunization Action Coalition
 - ▶ State of Missouri
 - ▶ DHSS
 - ▶ Bureau of Immunizations
 - ▶ SEMA
 - ▶ SNS/MCM Program





MISSOURI DEPARTMENT OF
HEALTH &
SENIOR SERVICES



Unit 5:

Injection Exercise

Vaccination Station

- ▶ Know your supplies
- ▶ Sharps Containers
 - ▶ No obstacles between a dirty needle and the sharps container
- ▶ Clients can not reach syringes or medication/vaccines
- ▶ Be cognizant of waste disposal (both biohazard and regular waste)
- ▶ Have cotton balls, gauze ready

What items do I need to give an injection?

- ▶ Two Alcohol Wipes



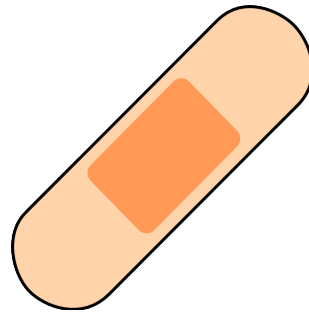
- ▶ Disposable gloves



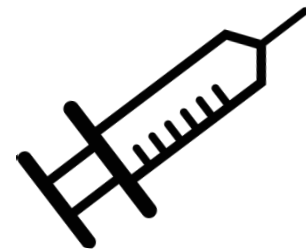
- ▶ One Cotton Ball



- ▶ One Band-Aid



- ▶ New needle and syringe make sure to pick proper size)



Select the Correct Needle Size

PATIENT AGE	INJECTION SITE	NEEDLE SIZE
Newborn (0-28 days)	Anterolateral thigh muscle	$\frac{5}{8}$ "* (22-25 gauge)
Infant (1-12 mos)	Anterolateral thigh muscle	1" (22-25 gauge)
Toddler (1-2 years)	Anterolateral thigh muscle	1-1 $\frac{1}{4}$ " (22-25 gauge)
	Alternate site: Deltoid muscle of arm if muscle mass is adequate	$\frac{5}{8}$ "-1" (22-25 gauge)
Children (3-10 years)	Deltoid muscle (upper arm)	$\frac{5}{8}$ "-1" (22-25 gauge)
	Alternate site: Anterolateral thigh muscle	1-1 $\frac{1}{4}$ " (22-25 gauge)
Children and adults (11 years and older)	Deltoid muscle (upper arm)	$\frac{5}{8}$ " [†] -1" (22-25 gauge)
	Alternate site: Anterolateral thigh muscle [‡]	1 $\frac{1}{8}$ "-1 $\frac{1}{2}$ " (22-25 gauge)

Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME _____

DATE OF BIRTH _____
month / day / year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a parent, brother, or sister with an immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had a seizure or a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever felt dizzy or faint before, during, or after a shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you anxious about getting a shot today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.



FOR PROFESSIONALS www.immunize.org / FOR THE PUBLIC www.vaccineinformation.org

www.immunize.org/catg.d/p4065.pdf
Item #P4065 (11/6/2023)



Patient Screening


- ▶ Ask if the patient has:
 - ▶ Allergies
 - ▶ Medical Conditions
 - ▶ Pregnancy
 - ▶ Previous Vaccines
 - ▶ Illness


Patient Education

► Vaccine Information Statements (VIS) are required by US Law

► They are provided for patient education

VACCINE INFORMATION STATEMENT	
Influenza (Flu) Vaccine (Inactivated or Recombinant): What you need to know	
1 Why get vaccinated?	<p>There is no live flu virus in flu shots. They cannot cause the flu.</p> <p>There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.</p> <p>Flu vaccine cannot prevent:</p> <ul style="list-style-type: none">• flu that is caused by a virus not covered by the vaccine, or• illnesses that look like flu but are not. <p>It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.</p>
2 Inactivated and recombinant flu vaccines	<p>Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.</p> <p>Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.</p> <p>Each year thousands of people in the United States die from flu, and many more are hospitalized.</p> <p>Flu vaccine can:</p> <ul style="list-style-type: none">• keep you from getting flu,• make flu less severe if you do get it, and• keep you from spreading flu to your family and other people. <p>A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.</p> <p>Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.</p>
3 Some people should not get this vaccine	<p>Tell the person who is giving you the vaccine:</p> <ul style="list-style-type: none">• If you have any severe, life-threatening allergies. If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.• If you ever had Guillain-Barré Syndrome (also called GBS). Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.• If you are not feeling well. It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

 U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction	5 What if there is a serious reaction?
<p>With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.</p> <p>Most people who get a flu shot do not have any problems with it.</p> <p>Minor problems following a flu shot include:</p> <ul style="list-style-type: none">• soreness, redness, or swelling where the shot was given• hoarseness• sore, red or itchy eyes• cough• fever• aches• headache• itching• fatigue <p>If these problems occur, they usually begin soon after the shot and last 1 or 2 days.</p> <p>More serious problems following a flu shot can include the following:</p> <ul style="list-style-type: none">• There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.• Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTap vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure. <p>Problems that could happen after any injected vaccine:</p> <ul style="list-style-type: none">• People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.• Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.• Any medications can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination. <p>As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.</p> <p>The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/</p>	<p>What should I look for?</p> <ul style="list-style-type: none">• Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior. <p>Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.</p> <p>What should I do?</p> <ul style="list-style-type: none">• If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.• Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967. <p><i>VAERS does not give medical advice.</i></p>
6 The National Vaccine Injury Compensation Program	7 How can I learn more?
<p>The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.</p> <p>Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.</p>	<ul style="list-style-type: none">• Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.• Call your local or state health department.• Contact the Centers for Disease Control and Prevention (CDC):<ul style="list-style-type: none">- Call 1-800-232-4636 (1-800-CDC-INFO) or- Visit CDC's website at www.cdc.gov/flu
<p>Vaccine Information Statement Inactivated Influenza Vaccine</p> <p>08/07/2015</p> <p>42 U.S.C. § 300aa-26</p> <p></p>	

Vaccine Contraindications

Guide to Contraindications and Precautions to Commonly Used Vaccines in Adults

Vaccine	Contraindications	Precautions ¹
Tetanus, diphtheria, pertussis (Tdap) Tetanus, diphtheria (Td)	<ul style="list-style-type: none">• Severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component• For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP/DTaP/Tdap	<ul style="list-style-type: none">• Moderate or severe acute illness with or without fever• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus toxoid-containing vaccine• History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least 10 years have elapsed since the previous dose• For Tdap only: Progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy: defer vaccination with Tdap until a treatment regimen has been established and the condition has stabilized.• For Td only: Unstable neurologic condition.

- ▶ Previous, life-threatening, reaction
- ▶ Minimum interval between vaccines
- ▶ Severe illness

Handwashing

Did you wash your hands?

Stop the spread of germs and be healthy.



WET

Wet hands under warm water.



WASH

Wash hands with soap for 20 seconds.



RINSE

Rinse under warm water.



DRY

Dry hands. Turn off water with paper towel.

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#257



Hand washing is the #1 way to prevent the spread of diseases!

Vaccine Administration Documentation

STATE OF MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES IMMUNIZATION CONSENT AND HISTORY										CLINIC IDENTIFICATION	
LAST NAME		FIRST NAME		MI	DATE OF BIRTH		SEX	PARENT/GUARDIAN FULL NAME			
STREET ADDRESS		CITY		STATE	ZIP CODE		TELEPHONE NO.				
RACE (SELECT ALL THAT APPLY)											
<input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White											
ETHNICITY											
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino											
I have been given copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.											
VACCINE AND ROUTE (CIRCLE TYPE GIVEN WHERE APPLICABLE)	VISIT NO. & M/D/Y GIVEN	INJECTION SITE	VACCINE MANUFACTURER/ LOT NUMBER	VACCINE EXP. DATE	VIS REVISION DATE	DATE VIS GIVEN	SIGNATURE OF VACCINATOR	PATIENT OR PARENT/GUARDIAN CONSENT			
Hepatitis B								VISIT #1 DATE			
Hep B	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Diphtheria, Tetanus, Pertussis								VISIT #2 DATE			
DTap DTP DT IM								SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Haemophilus influenzae type b								VISIT #3 DATE			
Hib	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Polio								VISIT #4 DATE			
Polio SQ IM								SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Pneumococcal								VISIT #5 DATE			
PCV 13	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
COMMENTS											

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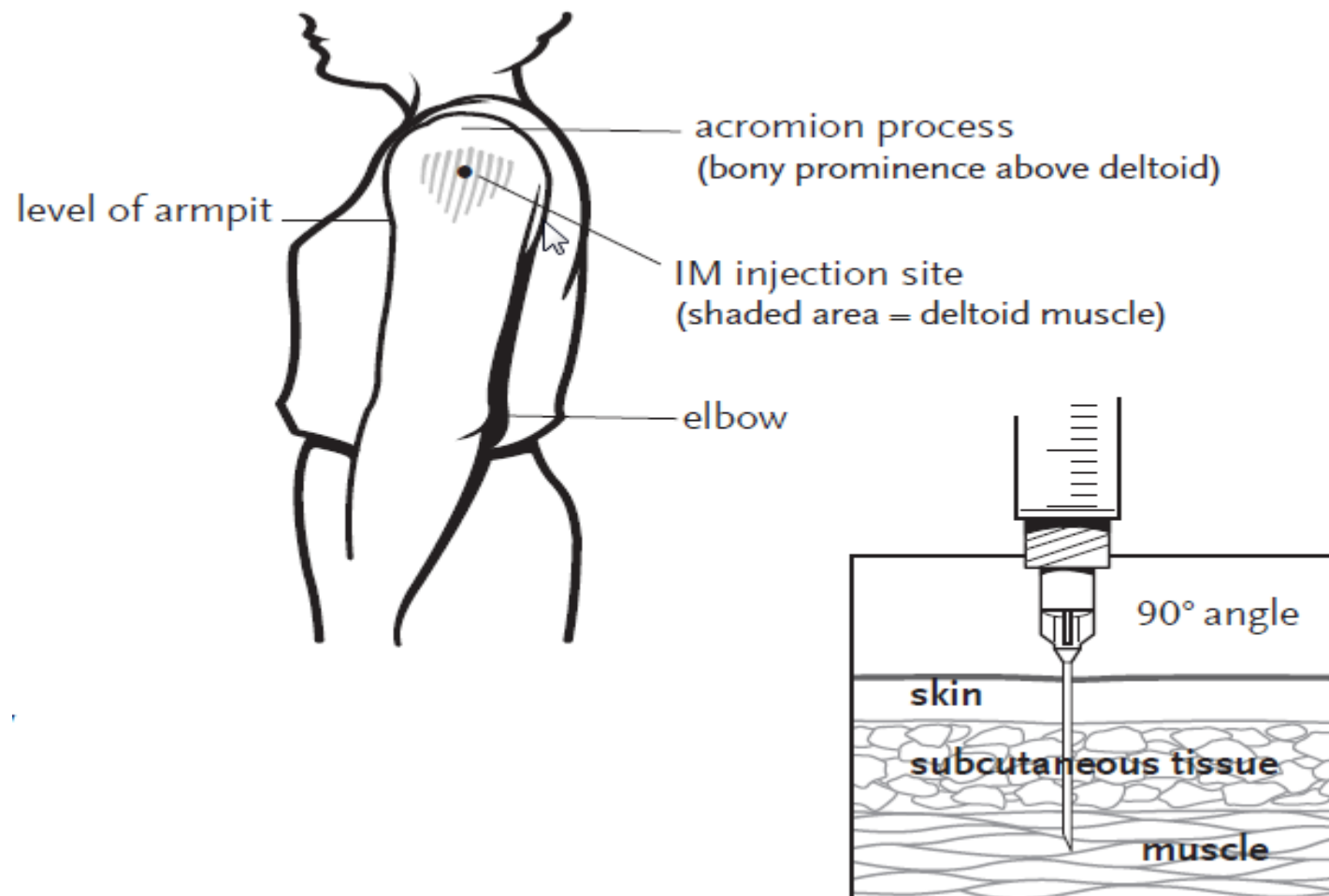
IMMUNIZATION CONSENT AND HISTORY (CONTINUED)										PATIENT NAME	
VACCINE AND ROUTE (CIRCLE TYPE GIVEN WHERE APPLICABLE)	VISIT NO. & M/D/Y GIVEN	INJECTION SITE	VACCINE MANUFACTURER/ LOT NUMBER	VACCINE EXP. DATE	VIS REVISION DATE	DATE VIS GIVEN	SIGNATURE OF VACCINATOR	PATIENT OR PARENT/GUARDIAN CONSENT			
Pneumococcal polysaccharide PPSV 23 SQ IM								VISIT #5 DATE			
Measles, Mumps, Rubella MMR SQ								SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Varicella								VISIT #6 DATE			
Varicella SQ								SIGNATURE			
Rotavirus								ELIGIBILITY STATUS			
RV1	Oral							<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
RV5	Oral							VISIT #7 DATE			
Hepatitis A								SIGNATURE			
Hep A	IM							ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Human papilloma-virus								VISIT #8 DATE			
HPV	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Meningococcal								VISIT #9 DATE			
MenACWY	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Meningococcal B								VISIT #10 DATE			
MenB	IM							SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Tetanus, Diphtheria, Pertussis (7 years old and above)								VISIT #11 DATE			
Tdap	IM							SIGNATURE			
Td	IM							ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Influenza								VISIT #12 DATE			
IV (inactive)	IM							SIGNATURE			
RIV (recombinant)	IM							ELIGIBILITY STATUS			
LAIV (live attenuated intranasal)	IN							<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Zoster (Shingles)								VISIT #13 DATE			
RVZ (recombinant)	IM							SIGNATURE			
ZVL (live)	SQ							ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
Other								VISIT #14 DATE			
Other								SIGNATURE			
								ELIGIBILITY STATUS			
								<input type="checkbox"/> Medicaid <input type="checkbox"/> No health insurance <input type="checkbox"/> Amer Indian/Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC) <input type="checkbox"/> NOT VFC Eligible			
COMMENTS											

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Site Selection for an IM Injection for an Adult

- ▶ Completely expose the upper arm (picture on next slide)
- ▶ Feel for the bone (acromion process) that goes across the top of the upper arm
- ▶ Find the injection site in the center of an upside-down triangle
 - ▶ The injection will go into the Deltoid muscle
 - ▶ The bottom of the acromion process bone form the base of the triangle, the point of the triangle is about the level of the armpit
 - ▶ The center is 1-2 inches below this bone
 - ▶ The site should not be used if the person is very thin or the muscle is very small

Know the Site - Get it Right!



Vaccine Administration

1. Wash hands with soap, dry them completely then put on gloves
2. Open alcohol wipe and wipe area where you plan to give an injection then let the area dry
3. Prepare the needle - hold the syringe with your writing/dominant hand, pull cover off with other hand, place syringe between your thumb and first finger
4. Hold skin around where you will give the injection and gently press on and pull skin so its slightly tight
5. Insert the needle into the muscle, hold syringe and use wrist to inject the needle through the skin and into the muscle at a 90 degree angle

Vaccine Administration

6. Use a quick motion, the quicker you put the needle in the less it hurts
7. Inject the medicine, push down on the plunger to inject the entire contents of the syringe
8. Remove the needle once medicine is injected at the same angle it went in
9. Place band-aid over the injection area
10. Dispose of retractable needle into sharps container

How do I get rid of used needles and syringes?



- ▶ Sharps containers are the best and safest way to dispose of needles
- ▶ DO NOT DISPOSE THEM IN THE TRASH!!!

Site Selection: Infants and Toddlers

- **For infants and toddlers:**



Have parent hold the child on parent's lap.

1. One of the child's arms embraces the parent's back and is held under the parent's arm.
2. The other arm is controlled by the parent's arm and hand. For infants, the parent can control both arms with one hand.
3. Both legs are anchored with the child's feet held firmly between the parent's thighs, and controlled by the parent's other arm.

Site Selection: Kindergarten and Older

- **For kindergarten and older children:**



Hold the child on parent's lap or have the child stand in front of the seated parent.

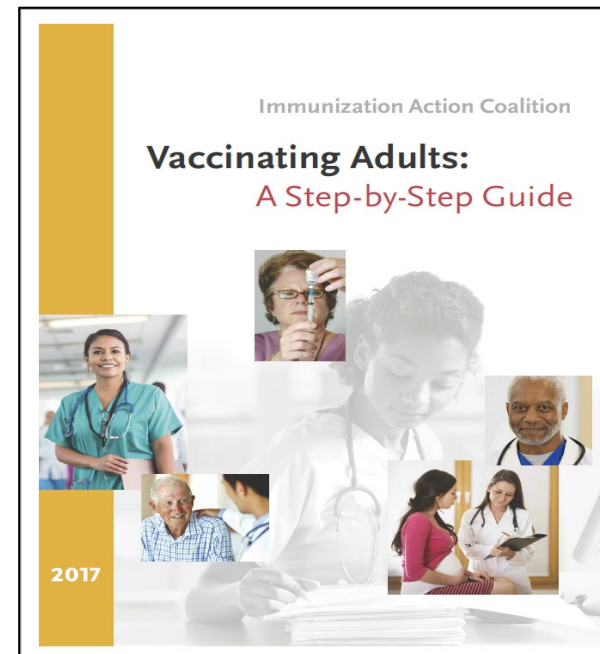
1. Parent's arms embrace the child during the process.
2. Both legs are firmly between parent's legs.



IMMUNIZATION
TECHNIQUES
Safe • Effective • Caring

Resources

- ▶ Information on medication dispensing and vaccine administration are available on the Resource Handout and Include:
 - ▶ Centers for Disease Control and Prevention
 - ▶ Immunization Action Coalition
 - ▶ State of Missouri
 - ▶ DHSS
 - ▶ Bureau of Immunizations
 - ▶ SEMA
 - ▶ SNS/MCM Program



Group Exercise

