# TAG B: Immunization and Communicable Disease Control



# TABLE OF CONTENTS

1.0	OVERVIEW	1
1.1	PURPOSE	1
1.2	IMMUNIZATION AND COMMUNICABLE DISEASE PLAN	1
2.0	IMMUNIZATION REQUIREMENTS AND PROCEDURES	2
2.1	<ul> <li>PRE-IMMUNIZATION PROCEDURES.</li> <li>2.1.1 Evidence of Prior Immunization</li> <li>2.1.2 Sensitivity Precautions.</li> <li>2.1.3 Reaction Precautions.</li> <li>2.1.4 Contraindications .</li> <li>2.1.5 Immunization Intervals.</li> <li>2.1.6 Mixing of Immunizing Agents .</li> <li>2.1.7 Expiration Dates.</li> <li>2.1.8 Mass Immunization .</li> <li>2.1.9 Exemptions and Waivers .</li> </ul>	3 3 3 4 4 5 5 5
2.2	IMMUNIZATION SCHEDULES 2.2.1 Indications for Primary Series	5 6
2.3	ADVERSE REACTIONS	6
3.0	BASIC IMMUNIZATIONS AND TESTS	7
3.1	TETANUS-DIPHTHERIA (TD) 3.1.1 Without Documentation 3.1.2 With Documentation	7 7 7
3.2	POLIOMYELITIS	7 8 8
3.3	MMR: MEASLES (RUBEOLA), MUMPS, AND RUBELLA (GERMAN MEASLES) 3.3.1 Without Documentation 3.3.2 With Documentation	8 8 8
3.4	HEPATITIS B VIRUS (HBV) 3.4.1 Students 3.4.2 Staff 3.4.3 Post Exposure	9 9 10 10
3.5	TUBERCULOSIS (TB) TESTING 3.5.1 Without Documentation	10 10

	3.5.2 With Documentation	11
4.0	ADDITIONAL IMMUNIZATIONS	12
4.1	INFLUENZA VACCINE	12
4.2	PNEUMOCOCCAL POLYSACCHARIDE VACCINE	13
4.3	HAEMOPHILUS INFLUENZAE TYPE B (HIB)	13
4.4	VARICELLA	13
4.5	HEPATITIS A	13
4.6	<ul> <li>IMMUNIZATION/PROPHYLAXIS TO BE USED AT THE TIME OF</li> <li>EXPOSURE TO CERTAIN DISEASES</li></ul>	14 14 14 15
5.0	PROCEDURES WHEN CASES OF INFECTIOUS DISEASE OCCUR ON CENTER	17
5.1	REPORTING PROCEDURES	17
5.2	SELECTED COMMUNICABLE DISEASES	18
6.0	MANAGEMENT OF IMMUNIZING AND OTHER BIOLOGICAL AGENTS	25
6.1	PURCHASE AND RECEIPT OF IMMUNIZING AGENTS	25
6.2	STORAGE	25
6.3	ADMINISTRATION	26
6.4	DISPOSAL	26
7.0	IMMUNIZATION RECORDS	27
7.1	IMMUNIZATION RECORD7.1.1Initiation7.1.2Record Entries and Storage7.1.3Copy of Immunization Record	27 27 27 27
7.2	OTHER IMMUNIZATION RECORDS 7.2.1 Records for Personnel Other than Students 7.2.2 Acceptance of Records of Prior Student Immunization	27 27 27

# LIST OF TABLES

1	Guidelines for Immunization of Students4
2	Primary Immunization Series for Persons ≥7 Years of Age5
3	Required Immunizations at Enrollment for Students without Documentation of Prior Immunizations9
4	Required Immunizations at Enrollment for Students with Documented Proof of Prior Immunizations9
5	Classifying the Tuberculin Reaction11
6	Tetanus Prophylaxis and Routine Management15
7	Post-Exposure Anti-Rabies Guide16
8	Suspected or Confirmed Cases of Communicable Disease to be Reported to State/Local Health Department17
9	Hepatitis A (HAV)
10	Hepatitis B (HBV)
11	Herpes Simplex (HSV)20
12	Chlamydial Infections (Chlamydia Trachomatis)21
13	Gonorrhea22
14	Syphilis23
15	Lyme Disease24

# APPENDICES

- A Job Corps Immunization Forms
- B CDC Vaccine Information Sheets
- C Vaccine Adverse Event Reporting

## 1.0 OVERVIEW

The immunization and communicable disease program at each Job Corps center shall include provision for personnel, supplies and equipment, and procedures necessary to provide students with basic and booster immunizations.

## 1.1 PURPOSE

The underlying purposes of the immunization and communicable disease program on Job Corps centers are to:

- Avoid communicable disease outbreaks that may be life threatening or, while not life threatening, may cause time lost from training.
- Support the Federal Government's public health effort to maintain high levels of immunization in the community.

## 1.2 IMMUNIZATION AND COMMUNICABLE DISEASE PLAN

Under the direction of the center physician, health services staff will implement immunization and communicable disease procedures according to written standing orders provided by the center physician. These standing orders will specify:

- Location—Where immunizations will be administered (e.g., center health unit, local health department).
- **Personnel**—Who is authorized by the center physician to administer immunizations. These must be administered by qualified center health professionals (i.e., physicians, nurse practitioners, nurses, physician's assistants).
- **Management of Immunizations**—Procedures and schedules for administering basic and other immunizations and tests, the individuals to be immunized, and documentation requirements (sample immunization forms are shown in Appendix A. Provisions must be made for possible serious reactions and for patient privacy.
- Management of Outbreaks of Communicable Disease—Procedures for handling outbreaks of communicable disease on center.
- Vaccine Management—Procedures for ordering, storing, and disposing of vaccines and toxoids.

## 2.0 IMMUNIZATION REQUIREMENTS AND PROCEDURES

Required basic immunizations include tetanus and diphtheria (Td) toxoid, inactivated (IPV) poliomyelitis vaccine, and measles, mumps, and rubella (MMR) vaccine. A Mantoux tuberculin skin test for tuberculosis is mandatory for all students<sup>1</sup>. Also, all health occupations training (HOT) students and health services staff must be offered the hepatitis B immunization series, and all individuals who may have been occupationally exposed to potentially infectious material(s) must be offered the vaccination post-exposure. In addition, immunizations are recommended against influenza, pneumococcal infection, and Haemophilus influenzae type b infection for persons with special health problems<sup>2</sup>. Routine polio vaccination is not recommended for persons 18 years of age and older who reside in the United States.

Since most students have been immunized previously in a health department, clinic, private office or in a school setting, they may already be fully immunized or require only boosters. A primary immunization series is only required for certain groups and under certain conditions.

In accordance with The National Childhood Vaccine Injury Act (NCVIA) of 1986, anyone who administers DTP (DTaP, Td, DT), MMR, hepatitis B, Haemophilus influenzae type b, varicella, and/or polio vaccines must provide detailed patient education information on the potential benefits and side effects of these immunizations before they are administered. A vaccine information statement (VIS) must be issued every time a vaccine (to include each dose of a multi-dose series) is administered. Appendix B provides information about the VISs produced by the Centers for Disease Control and Prevention (CDC) on the above vaccines covered under the NCVIA.

Center health providers are not required to obtain the signature of the student or the student's parent/guardian (if a minor) acknowledging receipt of the VIS. However, to document that the VIS was issued, center health staff should note in the student's medical record the date the VIS is given to the vaccine recipient. To ensure that parents/guardians of minors are provided with vaccine information statements, centers may elect to send the statements as part of the student's pre-arrival packet with a note explaining that vaccines will be given as indicated by the student's medical/vaccination history.

The NCVIA requires all health care providers who administer vaccines to maintain permanent vaccination records [see Section 7.0] and to report occurrences of certain adverse events specified in the Act [see Section 2.3].

<sup>&</sup>lt;sup>1</sup> Students with documentation of a positive TB test prior to Job Corps enrollment must produce a chest X-ray report on entry.

<sup>&</sup>lt;sup>2</sup>Special health problems include immunosuppressive therapy, conditions that compromise immune response (e.g., lymphoma, leukemia, malignancies, HIV infection), splenic dysfunction, congenital heart disease, sickle cell disease, and chronic illnesses such as diabetes mellitus, cardiovascular, renal, or bronchopulmonary disease.

The NCVIA establishes an alternative to civil litigation and specifies vaccines covered by the program, conditions for which compensation may be paid without proof of causation, and the time period during which symptoms must first appear. Recorded information is available 24 hours per day by calling (800) 338-2382, or online (www.hrsa.dhhs.gov/bhpr/vicp/new.htm). Centers should call (202) 219-9657 for claims information.

## 2.1 PRE-IMMUNIZATION PROCEDURES

## 2.1.1 Evidence of Prior Immunization

To avoid immunizing students unnecessarily, center health staff must make a strong effort to obtain evidence of prior immunization. Job Corps admissions counselors are encouraged to have the applicant obtain such documentation from family, school, or health department/clinic and bring it to the center at the time of enrollment. Centers are encouraged to include a reminder of immunization documentation in pre-arrival letters or phone calls to applicants. The center must receive an official statement within 14 days after the student's arrival that attests to the current immune status of the individual by noting date(s) and dose(s) of immunization(s) [see Section 7.2.1].

## 2.1.2 Sensitivity Precautions

Prior to the injection of any biological product, center health staff will determine whether the individual has previously shown a significant sensitivity to a foreign protein. Individuals reporting a history of sensitivity to an immunizing agent usually should be exempt from that immunization. Persons with significant allergy to eggs or fowl should not be given vaccine prepared by cultivation in eggs (e.g., influenza vaccine).

## 2.1.3 Reaction Precautions

Prior to the administration of any immunizing agent, center health staff will make provisions for immediate first aid and medical care for any anaphylactic reaction that may occur. The center physician is responsible for establishing, in writing, appropriate emergency procedures including the use of any drugs (with dosages) in case of immunization reactions.

#### EMERGENCY KIT

- Syringe with needle
- Aqueous epinephrine in a 1:1,000 solution
- A potent injectable antihistamine (e.g. diphenhydramine hydrochloride)
- A fast-acting injectable corticosteroid (e.g., hydrocortisone sodium succinate)
- An albuterol metered dose inhaler

#### 2.1.4 Contraindications

Immunizations may be contraindicated during pregnancy because of theoretical concerns about effects on the fetus. Live virus vaccines (MMR, varicella) will not be administered during pregnancy. When possible, inactivated vaccines and toxoids should be delayed until the second or third trimester.

Center health staff must follow the CDC guidelines with respect to HIV testing when administering immunizations and vaccines to students [see Table 1].

TABLE 1: GUIDELINES FOR IMMUNIZATION OF STUDENTS				
VACCINE	PRE-RESULTS*	HIV NEGATIVE	HIV POSITIVE	
Td	Yes**	Yes	Yes	
IPV	Yes	Yes	Yes	
MMR	No	Yes	(optional)	
Mantoux Test	Yes	Yes	Yes	
Pneumococcal	No	(optional)	Yes	
Haemophilus influenzae b	No	(optional)	Yes	

\*Given before HIV test result is known

\*\*Yes = Immunize; No = Do not immunize

#### 2.1.5 Immunization Intervals

The prescribed time intervals between individual doses of an immunization series as outlined in Section 2.2 are optimal and must be followed as closely as possible. If a delay occurs in the completion of a series, administer the next dose at the earliest opportunity. An interrupted series need not be re-started. Giving immunizations at less than the recommended intervals may lessen the antibody response and should not be counted as part of a primary series. The prescribed optimal intervals between doses will not be reduced without a written order by the center physician.

Multiple immunizations may be administered on the same day at different sites. Simultaneous administration will not result in impaired antibody responses or an increase in adverse reactions. However, there are theoretical concerns that the immune response to one live-virus vaccine might be impaired if given between 1 and 30 days of another. Live-virus vaccines not administered on the same day should be given at least 30 days apart.

Live-virus vaccines can interfere with the response to a tuberculin test. Tuberculin testing can either be done on the same day the live-virus vaccines are administered or 4 to 6 weeks afterwards.

#### 2.1.6 Mixing of Immunizing Agents

Two or more immunizing agents will not be mixed in a syringe for the purpose of administering a single, simultaneous injection unless they are premixed by the manufacturer (e.g., MMR, tetanus and diphtheria toxoid). Mixing of immunizing agents by other than the manufacturer may result in biologically and/or physically incompatible products that are not potent immunologically and/or cause adverse reactions.

## 2.1.7 Expiration Dates

Immunizing agents will not be used after the stated expiration date.

#### 2.1.8 Mass Immunization

When mass immunization is required, an electric or automatic injection device may be used.

#### 2.1.9 Exemptions and Waivers

- **Exemptions**—The center physician may grant exemptions for individual students. The medical reasons for the exemption will be clearly written in the student's health record. Exemption will be based on a reliable history of significant sensitivity to an immunizing agent or other medical contraindication.
- **Waivers**—The center physician may grant waivers of immunization requirements for religious reasons. The waiver must be documented in the student's health record.

## 2.2 IMMUNIZATION SCHEDULES

Some immunizations require administration of more than one dose for development of an adequate antibody response. In addition, some immunizations require periodic reinforcement (booster) doses to maintain protection. The recommended immunization schedule for persons  $\geq$ 7 years of age (primary series) who were not previously immunized is listed in Table 2.

TABLE 2: PRIMARY IMMUNIZATION SERIES FOR PERSONS >7 YEARS OF AGE				
TIMING	VACCINE(S)	COMMENTS		
First visit	Td#1, IPV#1, MMR#1	IPV not to be given to persons $\geq$ 18 years		
2 months after visit 1	Td#2, IPV#2, MMR#2			
6-12 months after visit 2	Td#3, IPV#3			
10 yrs after Td#3	Td	Repeat every 10 years throughout life		

## 2.2.1 Indications for Primary Series

In many countries, children and adolescents are not routinely immunized. Students raised outside the United States must provide a record documenting the receipt of required immunizations at appropriate intervals, or laboratory evidence of immunity. If these students are unable to provide this information, they must receive a primary series of immunizations [see Table 2].

Students raised in the United States may not have documentation of prior immunizations. The center must make strong efforts to obtain this documentation [see 2.1.1]. For students without documentation, the center must at least give the required booster doses at enrollment. The center physician may elect to obtain serology for evidence of immunity before administering a primary series of immunizations. Students with evidence of immunity do not require a primary series.

## 2.3 ADVERSE REACTIONS

Centers must discontinue use of a vaccine lot whenever significant manifestations

occur that may be due to the use of a biologic product. Centers will (1) report the reaction as a significant medical incident [refer to PRH-5, Section 5.5], (2) notify the Job Corps National Office and the State or local health department, if required, and (3) retain the biologic materials under suspicion, including both open and unopened packages, pending receipt of

	Adverse Reactions			
•	Local or constitutional reactions of unexpected severity or frequency			

- Local infection
- Abscess formation not traceable to error in administration technique

instructions from the manufacturer regarding disposition of the suspected materials.

Center health staff must record severe individual sensitivity reactions to any biologic agent or drug in the immunization records, indicating the offending substance, its lot number and manufacturer, site of administration, the date administered, and the severity of reaction. Center health staff is also required to report selected adverse events occurring after immunization to the Vaccine Adverse Events Reporting System (VAERS). Appendix C provides information about VAERS and the table of reportable events following vaccination. VAERS forms and instructions are also available through the VAERS internet site (www.cdc.gov/nip/vaers.htm), in the *Physicians' Desk Reference*, or by calling VAERS at (800) 822-7967.

## 3.0 BASIC IMMUNIZATIONS AND TESTS

This section presents immunization procedures for tetanus-diphtheria, poliomyelitis, measles-mumps-rubella, and hepatitis B and testing procedures for tuberculosis. Each immunization or test is described by the following factors, where applicable:

- Restrictions on use of the vaccine or test
- Nature of the vaccine or test
- Recommended procedures for students without documentation
- Recommended procedures for students with documentation
- Recommended procedures for HIV positive students
- Center options on procedures

Tables 3 and 4 (at the end of this section) summarize the specific immunizations, schedules, and center options for students with and without documentation.

## 3.1 TETANUS-DIPHTHERIA (TD)

## 3.1.1 Without Documentation

- For individuals who do not have documentation of prior immunization, give a single booster injection of adult Td at enrollment. The center should proceed with efforts to obtain documentation, and if not received within 30 days, the center physician may exercise the option to administer the primary series.
- For persons raised outside the U.S., who do not have evidence of prior immunization, administer the primary series [see Table 2].

## 3.1.2 With Documentation

- If documentation indicates that immunization was given more than 10 years ago, give a booster injection regardless of whether a complete or incomplete series was administered.
- For students who provide documentation of immunization against Td <u>within</u> the last 10 years, the following is required:
  - If an incomplete series was administered (i.e., one or two doses only) give a booster injection.
  - If a complete series was administered, no further immunization is needed.

## 3.2 POLIOMYELITIS

For routine prophylaxis, administer inactivated poliovirus vaccine (IPV) to students under 18 years of age; poliovirus vaccine is not recommended for persons 18 years of age and older.

#### 3.2.1 Without Documentation

- For all students under 18 years of age without documented proof of complete immunization, give an IPV booster at the time of enrollment.
- For students under 18 years of age born outside the U.S., who do not have evidence of prior immunization, give the primary series [see Table 2].

#### 3.2.2 With Documentation

For all individuals who provide documentation of vaccination against poliomyelitis, do the following:

- If an incomplete series was administered, administer a booster dose.
- If a complete series was administered, no further immunization is needed.

# 3.3 MMR: MEASLES (RUBEOLA), MUMPS, AND RUBELLA (GERMAN MEASLES)

MMR vaccination is indicated for students who have not received two doses after 12 months of age. The dosage is 0.5 ml given subcutaneously. Two precautions apply when administering the vaccine:

- Do not administer the MMR vaccine to any student with an altered immune status (including HIV, agammaglobulinemia, or malignancy) or who are receiving steroid or other immunosuppressive therapy, unless specifically ordered by the center physician.
- Inform non-pregnant females that they should not become pregnant for 28 days after MMR vaccination because of theoretical risk to the fetus. Do not administer the vaccine to pregnant students. Pregnant students should be immunized immediately after delivery or termination of the pregnancy.

#### 3.3.1 Without Documentation

- For individuals who do not have documentation of prior immunization, administer a single 0.5 ml dose of MMR vaccine subcutaneously.
- For persons raised outside the U.S., who do not have evidence of prior immunization, administer the primary series [see Table 2].

#### 3.3.2 With Documentation

The following is required for all students who provide documented proof of immunization against measles, mumps, and rubella:

- If only one dose of MMR was given after 12 months of age, give a booster dose of MMR vaccine.
- If two doses of MMR were given after 12 months of age, no further immunization is needed.

TABLE 3: REQUIRED IMMUNIZATIONS AT ENROLLMENT FOR STUDENTS         DOCUMENTATION OF PRIOR IMMUNIZATIONS			
VACCINE ALL STUDENTS STUDENTS RAISED OUTSIDE U.S.			
Tetanus-diphtheria toxoid (Td)	Booster	Primary series	
Polio (IPV) Students <18 yrs Students ≥18 yrs	Booster None	Primary series None	
Measles-Mumps-Rubella (MMR)	One dose	Primary series	

TABLE 4: REQUIRED IMMUNIZATIONS AT ENROLLMENT FOR STUDENTS       WITH         DOCUMENTED PROOF OF PRIOR IMMUNIZATIONS				
VACCINE	DOCUMENTATION OF PREVIOUS IMMUNIZATION	IMMUNIZATION REQUIRED		
Tetanus-diphtheria toxoid (Td)	Within 10 years	None		
	Over 10 years	Booster		
Polio (IPV)	<3 doses	Booster		
Students <18 yrs	3 doses	None		
Polio (IPV)				
Students <u>&gt;</u> 18 yrs	None	None		
Measles-Mumps-Rubella (MMR)	One dose after 12 months of age	Single dose		
	Two doses after 12 months of age	None		

## 3.4 HEPATITIS B VACCINE (HBV)

The recommended series consists of three 0.5 ml IM doses of HBV vaccine in the deltoid muscle. The first two doses are given 1 month apart and the third dose is given 5 months after the second dose. This schedule is preferred for adolescents; however, if the vaccine series is interrupted after the first dose, the second and third doses should be given separated by an interval of 3 to 5 months.

## 3.4.1 Students

Centers are required to offer hepatitis B vaccination to health occupations training (HOT) students, to begin 6 weeks prior to on-site clinical work experience. Each center must decide whether serologic screening is cost effective. Vaccination of individuals

who already have antibodies to HBV has not been shown to have adverse effects. Students must sign a consent or declination form, which must be placed in each student's health record.

Centers may elect to offer hepatitis B vaccine as an option for all students in locations where the vaccine is available at no cost from public sources.

#### 3.4.2 Staff

Centers must offer hepatitis B vaccination to all personnel identified at risk in the center's bloodborne pathogen plan. Again, each center must decide whether serologic screening is cost-effective. Staff must sign a consent or declination form, which must be placed in the employee's personnel record.

## 3.4.3 Post Exposure

Post-exposure vaccinations will be offered to those individuals who provide health care or render first aid only as a collateral duty. Post-exposure vaccinations must be offered as soon as possible, but no later than 24 hours after exposure. These individuals must also sign a consent or declination form, which must be documented in the employee's personnel record or student's health record.

## 3.5 TUBERCULOSIS (TB) TESTING

Tuberculosis testing is required of all students. The Mantoux method for intradermal testing with intermediate strength purified protein derivative (PPD) tuberculin, <u>5 Todd</u> <u>Units</u> (TU), will be used for all screening.

#### 3.5.1 Without Documentation

A TB skin test is required for all students without documentation of a negative test within 12 months. The procedure for test administration is as follows:

- Administer 0.1 ml PPD intradermally.
- Read the test 48 to 72 hours after administration. Record induration in mm.
- Repeat testing at 12 months for all HOT students with negative skin tests.

TABLE 5: CLASSIFYING THE TUBERCULIN REACTION			
≥5mm is positive in:	<ul> <li>Students who are HIV positive</li> <li>Students who have had close contacts with persons with infectious TB</li> <li>Students who have a chest radiograph suggestive of previous TB</li> <li>Students with clinical evidence of tuberculosis</li> <li>Students who inject drugs</li> </ul>		
≥10mm is positive in:	<ul> <li>Students with certain medical conditions, excluding HIV infection</li> <li>Foreign-born students from areas where TB is common</li> <li>Medically underserved, low-income populations including high-risk racial and ethnic groups (including the homeless)</li> </ul>		
>15mm is positive in:	<ul> <li>All students with no known risk factors for TB</li> </ul>		

## 3.5.2 With Documentation

For students with documentation of a TB test within the past 12 months, the following procedures will be followed:

- Retest using Mantoux method if multiple puncture tests (tine) was previously used.
- If the previous Mantoux results were equivocal or positive, arrange for a chest x-ray and evaluate further for preventive or curative therapy.
- If the previous Mantoux results were negative, retest only HOT students after 12 months.

## 4.0 ADDITIONAL IMMUNIZATIONS

In addition to the basic immunizations outlined in Section 3.0, the following immunizations are <u>suggested</u> for certain students and staff, as indicated.

- Influenza
- Pneumococcal Polysaccharide
- Haemophilus Influenzae Type B (Hib)
- Varicella
- Hepatitis A

Meningococcal, Tetanus, and Rabies immunizations are to be used at the time of exposure.

#### 4.1 INFLUENZA VACCINE

Annual vaccination for influenza is <u>strongly recommended</u> for students who are at increased risk of adverse consequences from infections of the lower respiratory tract. All other students may be considered for vaccination to minimize the disruption of routine activities during outbreaks or epidemics.

Considerations involving the use of influenza vaccine are as follows:

- Vaccination should be done annually, using the vaccine prepared for the current year. Each year's vaccine contains three virus strains most likely to circulate in the upcoming winter.
- Adults and children over 9 years need only <u>one</u> 0.5 ml IM dose of vaccine. The recommended site of vaccination is the deltoid muscle.
- Vaccination of HIV-positive persons is considered a prudent precaution against more serious illness and complications arising from influenza infection.
- Influenza vaccine is generally considered safe for pregnant women. Administering the vaccine after the first trimester is a reasonable precaution to minimize any concern over the theoretical risk of teratogenicity.
- Individuals with a history of sensitivity to eggs or chick protein should <u>not</u> be given the vaccine.
- Centers may elect to vaccinate all consenting students and staff in an effort to reduce the incidence, lessen the severity, and shorten the duration of cases which may be expected to occur during the influenza season.
- The vaccine may be offered to persons presenting for care beginning in October (but <u>not</u> until the new vaccine is available), and continuing through the influenza season.

In the case of a widespread outbreak or community epidemic, center health staff may consider the use of amantadine or rimantadine for prophylaxis and/or treatment of influenza. In a nationwide epidemic, the National Office will provide current recommendations and instructions.

#### 4.2 PNEUMOCOCCAL POLYSACCHARIDE VACCINE

The recommended immunization is a single IM dose of the currently available polyvalent pneumococcal vaccine. This vaccine can be given at the same time as the influenza vaccine. Re-vaccination is advisable 5 years after initial vaccination because of declining antibody levels.

## 4.3 HAEMOPHILUS INFLUENZAE TYPE B (HIB)

Most healthy persons are not at increased risk of invasive Hib disease. Invasive disease occurs primarily among adults with chronic disease and persons with underlying conditions that predispose to infections with encapsulated bacteria, especially persons with HIV infection. Because of this risk, immunization with the Haemophilus influenzae type b conjugate vaccine (HbCV) is recommended for students with HIV infection.

#### 4.4 VARICELLA

Approximately 20 percent of U.S. adolescents are susceptible to varicella infection (chickenpox). The complication risk from varicella is greatest for individuals age 15 and older. Varicella vaccine is administered in two 0.5 ml doses subcutaneously (SC) 4 to 8 weeks apart for persons age 13 and older. Contraindications include pregnancy and immunosuppression as this is a live, attenuated viral vaccine.

Centers may elect to offer varicella vaccine as an option for all students with no reported history of chickenpox in locations where the vaccine is available at no cost from public sources. Serologic screening is not cost effective in this circumstance.

Outbreaks of varicella on center should be managed with initial isolation, followed by medical leave at home until all lesions have crusted and dried, usually within 1 week.

#### 4.5 HEPATITIS A

Indications for hepatitis A vaccine among Job Corps students include chronic liver disease, administration of clotting factors, illicit drug use, and homosexually active males. The vaccine is available in a two-dose regimen, given 6 to 12 months apart. Postexposure immunoprophylaxis is available with immune globulin 0.02 ml/kg deep IM.

Centers may elect to offer hepatitis A vaccine as an option for all students in locations where the vaccine is available at no cost from public sources.

## 4.6 IMMUNIZATION/PROPHYLAXIS TO BE USED AT THE TIME OF EXPOSURE TO CERTAIN DISEASES

#### 4.6.1 Meningococcal Infection

*Neisseria meningitidis* is the leading cause of bacterial meningitis in older children, adolescents, and young adults. Incidence peaks in late winter and early spring, and the case fatality rate is 13 percent with meningitis and 11.5 percent with meningococcemia. Meningococcal antimicrobial prophylaxis should be administered to close contacts within 24 hours of index case identification. Alternatives include rifampin 600 mg by mouth every 12 hours for 2 days (four doses), ciprofloxacin 500 mg by mouth once <u>or</u> ceftriaxone 250 mg IM once. Nasopharyngeal cultures are not indicated, and prophylaxis is of no value more than 14 days after index case identification.

A quadrivalent polysaccharide meningococcal vaccine is available as a single 0.5 ml subcutaneous (SC) injection. Protective levels of antibody are achieved in 7 to 10 days, but antibody titers markedly decline over 3 years. Centers should consult with State/local health authorities before considering the use of meningococcal vaccine in an outbreak or cluster.

Centers may elect to offer meningococcal vaccine as a preventive option for all residential students in locations where the vaccine is available at no cost from public sources.

## 4.6.2 Tetanus Prophylaxis in Wound Management

The physician often needs to consider active <u>and</u> passive immunization as part of wound management. The decision to immunize should be based on the history of previous tetanus vaccinations and the condition of the wound.

Available evidence indicates that antibodies persist at protective levels for at least 10 years after a primary series of tetanus toxoid immunizations. Therefore, any student who, before entry into Job Corps, received three immunizations of tetanus toxoid does not require a booster injection as part of the management of clean minor wounds unless 10 or more years have elapsed since the last dose.

Table 5 is a guide to active and passive tetanus immunizations following the occurrence of a wound. Attempts should be made to determine whether a patient has completed primary immunization. If passive immunization is needed, human tetanus immune globulin (TIG) is to be given. The recommended prophylactic dose is 250 units of TIG for wounds of average severity.

TABLE 6: TETANUS PROPHYLAXIS AND ROUTINE MANAGEMENT				
HISTORY OF TETANUS	CLEAN, MINOR WOUNDS		ALL OTHER WOUNDS <sup>4</sup>	
IMMUNIZATION	Td	TIG	Td	TIG
Unknown or less than 3 doses	Yes	No	Yes	Yes
Three or more doses	Yes⁵	No	No <sup>6</sup>	No

#### 4.6.3 Rabies Prophylaxis: Treatment of Persons Bitten by Animals

The management of individuals who are bitten by animals has been systematized to ensure adequacy of rabies prophylaxis and to avoid unnecessary treatment. Specific recommendations for treatment of bites by particular animals are shown in Table 6.

Two inactivated rabies vaccines are currently licensed for post exposure prophylaxis in the U.S. Only human diploid cell vaccine (HDCV) is generally available. After a potential exposure to rabies, persons who have not previously been immunized against rabies should be treated with a single 20 IU/kg dose of human rabies immune globulin (HRIG) and five 1 ml IM doses of HDCV: one each on days 0, 3, 7, 14, and 28. Only the deltoid muscle is acceptable for HDCV administration.

HRIG should be administered at the beginning of HDCV post-exposure prophylaxis, but can be given through the seventh day after the first dose of HDCV was given. The HRIG dose should be divided; up to half should be infiltrated in the area of the wound, if possible, and the rest should be administered IM.

<sup>&</sup>lt;sup>4</sup>All other wounds including, but not limited to: wounds contaminated with dirt, feces, soil, etc.; puncture wounds; avulsions; and recent wounds from crushing, burns, and frostbite.

<sup>&</sup>lt;sup>5</sup>Yes, if more than 10 years since last dose.

<sup>&</sup>lt;sup>6</sup>Yes, if more than 5 years since last dose (more frequent boosters are not required.)

TABLE 7: POST-EXPOSURE ANTI-RABIES GUIDE <sup>7</sup>				
ANIMAL AND SPECIES	CONDITION AT TIME OF ATTACK	TREATMENT		
Wild (Bat, skunk, raccoon, fox, woodchuck)	Regard as rabid	HRIG, Vaccine <sup>8</sup>		
	Healthy (observable)	None <sup>9</sup>		
Domestic (Dog or Cat)	Escaped (unknown)	Consult local public health officials		
	Rabid (suspected)	HRIG, Vaccine		
Other		Consult local public health officials		

Rabies <u>pre-exposure</u> prophylaxis may be considered for students at risk of occupational exposure, such as animal control or wildlife workers. Three doses of HDCV are given intramuscularly (1.0 ml IM) <u>or</u> intradermally (0.1 ml ID) on days 0, 7, and 21 <u>or</u> 28. Serologic testing or booster vaccination may be needed every 2 years.

<sup>&</sup>lt;sup>7</sup>The recommendations are only a guide and should be used in conjunction with knowledge of the animal species involved, circumstances of the bite or other exposure, vaccination status of the animal, and presence of rabies in the region. A physician should always be consulted to determine dosages and routes of immunization.

<sup>&</sup>lt;sup>8</sup>Discontinue vaccine if fluorescent antibody tests of animal killed at time of attack are negative.

<sup>&</sup>lt;sup>9</sup>Begin HRIG and vaccine at first sign of rabies in biting dog/cat during 10-day holding period.

## 5.0 PROCEDURES WHEN CASES OF INFECTIOUS DISEASE OCCUR ON CENTER

The most prevalent, reportable communicable diseases found in Job Corps students are: outbreaks of respiratory infections (e.g., influenza) and individual cases of chlamydia, gonorrhea, herpes, hepatitis, meningitis, and tuberculosis. In the event that cases of serious communicable diseases occur on center, the Center Director will:

- Arrange for the immediate examination by a physician or qualified health professional of all affected center personnel and students.
- Assure that all cases are handled in accordance with current CDC recommendations and guidelines.

Prevention of epidemics depends on quick and appropriate responses to the <u>first case</u> diagnosed.

## 5.1 **REPORTING PROCEDURES**

The guidelines in this section are required for use by each center for the control and treatment of cases of communicable diseases occurring on center. The guidelines have been prepared in conjunction with recommendations from the CDC and those established in the latest edition of the American Public Health Association publication, *Control of Communicable Diseases in Man.* It must be emphasized that these are only general guidelines and that some situations may require a somewhat different approach.

The Center Director must immediately report significant medical incidents to the National Office of Job Corps, with an information copy to the Regional Office [see PRH-5, Section 5.5]. Significant medical incidents include a severe reaction to the administration of an immunization, or any outbreak or epidemic of an infectious disease, such as hepatitis, food poisoning, influenza, or scarlet fever. In addition, all suspected or confirmed cases of communicable disease will be reported to the State/local health department, when applicable.

TABLE 8: SUSPECTED OR CONFIRMED CASES OF COMMUNICABLE DISEASE TO BE         REPORTED TO STATE/LOCAL HEALTH DEPARTMENT			
Botulism	Hepatitis (A,B,C)	Poliomyelitis	
Lyme Disease	HIV infection/AIDS	Tetanus	
Chicken Pox (Varicella)	Measles (Rubeola)	Tuberculosis	
Diphtheria	Meningitis	Rabies	
German Measles (Rubella)	Mumps	Syphilis (Primary/Secondary <sup>10</sup> )	

<sup>&</sup>lt;sup>10</sup>Centers should report primary or secondary syphilis clinically diagnosed by the center physician. Do not report positive laboratory test results alone.

Each State requires that specific diseases be reported. Centers should establish working relationships with their State or local health department and report required information to appropriate departments.

## 5.2 SELECTED COMMUNICABLE DISEASES

Tables 9 through 15 provide brief descriptions of several frequently occurring communicable diseases in Job Corps. Guidelines for management of cases and contacts are provided. For a more detailed discussion of these and other communicable diseases, refer to <u>Control of Communicable Diseases Manual<sup>11</sup></u>

TABLE 9: HEPATITIS A (HAV)				
Identification	Abrupt onset with fever, malaise, anorexia, and nausea followed in a few days by jaundice.			
Diagnosis	Febrile jaundice confirmed by laboratory finding of antibodies against the hepatitis A virus in serum of an acutely or recently ill patient.			
Transmission	Person-to-person by fecal-oral route peaking at 1 to 2 weeks <u>before</u> symptoms and diminishing rapidly after symptoms and jaundice appear. Common source epidemics from contaminated food and water also occur. May also be transmitted during sexual contact.			
Incubation Period	Average 28 to 30 days, ranging from 15 to 50 days. Second case may not appear until 2 to 7 weeks after the first, except in common source epidemics.			
Preventive Measures	Educate students and staff about careful handwashing after using the toilet, especially before food preparation.			
	Dispose of feces carefully.			
	<b>Reporting:</b> Report each case to the Regional Office with a copy to the National Office and to State/local health department (S/LHD).			
	<b>Isolation:</b> Isolate patient for 1 week after onset of jaundice on center if facilities are suitable, or at home, or in hospital.			
Control Measures	<b>Immunization of Contacts:</b> Passive immunization within 2 weeks of exposure with Immune Globulin (IG) 0.02 ml/kg. Give IM in deltoid muscle as soon as possible after exposure to close contacts (i.e., students sharing bedroom or dormitory, regular classmates).			
	<b>Food Handlers:</b> Isolate student if case appears in a food handler; give IG to other food handlers.			
	<b>Control of Outbreaks:</b> Ask S/LHD to investigate if two or more cases appear on center at one time, or within 2 to 3 weeks of each other. If <u>authorized</u> by LHD and center physician, give IG to all on center. Consider stopping input of new students if new cases keep appearing.			
Admission/Readmission	Reject applicant who is jaundiced. Admit after jaundice disappears and a health facility or MD has discharged applicant.			

<sup>&</sup>lt;sup>11</sup>Information in Tables 9 to 15 has been abstracted from Control of Communicable Diseases Manual, 16th Edition, 1995.

TABLE 10: HEPATITIS B (HBV)					
Identification	Usually slow with abdominal discomfort, nausea, vomiting, etc., often progressing to jaundice. Fever may be mild or absent. Rashes and joint pain may also occur.				
Diagnosis	Confirmed by laboratory finding of hepatitis B surface antigen or recent development of antibodies in patient's serum.				
Transmission	Infectious blood, saliva, semen, and vaginal fluids. Percutaneous exposure through contaminated needles, syringes, and other intravenous equipment, especially among drug users. Sexual contact. Health care workers exposed through percutaneous or mucous membrane exposure to patient's blood or saliva.				
Incubation Period	Average 60 to 90 days with range of 45 to 180 days. The period of communicability may occur many weeks before onset of symptoms and last through acute clinical stage. Carrier state may last for years.				
Preventive Measures <sup>12</sup>	Vaccinate health care personnel and HOT students likely to come in <u>contact</u> with blood. Use new syringe and needle for each individual requiring skin tests, other parenteral inoculations, or venipuncture.				
Control Measures	<ul> <li>Reporting: Report each case to S/LHD and to the Regional Office with a copy to the National Office.</li> <li>Isolation: Isolate patient on center if acutely ill; otherwise send home or hospitalize. If health staff handles blood and body fluids, use universal precautions.</li> <li>Immunization of Contacts: As soon as possible, immunize contacts with HBIG 0.06 ml/kg IM and initiate HBV series. Possible contacts for HBV are unvaccinated health providers, sexual contacts, and persons sharing syringes, needles, and other illicit drug equipment.</li> <li>Food Handlers: Not at special risk.</li> <li>Control of Outbreaks: Same as for HAV, but HBIG is not required for all on center</li> </ul>				
Admission/Readmission	Same as for HAV.				

<sup>&</sup>lt;sup>12</sup>Also refer to PRH-5, Section 5.13 (R8), Bloodborne Pathogen Control Plan. This plan, required by the Occupational Safety and Health Administration, must be available on center.

TABLE 11:	HERPES SIMPLEX (HSV) (Human Herpes Virus 1 and 2)
	Viral infection characterized by a localized primary lesion and a tendency to localized recurrence.
	<b>HSV Type 1:</b> Primary infection with fever and malaise, gingivostomatitis with vesicular lesions in the oropharynx. Reactivation is precipitated by trauma, fever, physiological changes, or intercurrent disease.
Identification	<b>HSV Type 2:</b> Produces genital herpes. Occurs principally in adults and is sexually transmitted.
	<b>In Women:</b> Principal site of primary disease is the cervix and vulva; recurrent episodes involve the vulva, perineal skin, legs, and buttocks. Vaginal delivery by pregnant women with active genital infection carries high risk of infection to newborn.
	In Men: Lesions appear on the glans penis or prepuce, and in the anus and rectum of homosexually active males.
Diagnosis	HSV types 1 and 2 can be differentiated immunologically. Confirmed by direct fluorescent antibody staining or isolation of the virus from lesions.
Transmission	HSV type 1 by contact with lesions or saliva of carriers. HSV type 2 usually by sexual contact. Both types may be transmitted during sexual contact.
Incubation Period	Secretion of HSV type 1 in the saliva can last as long as 7 weeks after recovery. Primary genital lesions are infective for about 7 to 12 days. Reactivation may be asymptomatic with viral shedding only.
Proventive Measures	Provide personal hygiene and health education regarding transmission of the disease.
Fleventive measures	For health personnel, wear gloves when in direct contact with infected lesions. Avoid contaminating the skin with infectious material.
	<b>Reporting:</b> Report to S/LHD, if required.
	Isolation: None
	Immunization of Contacts: None
Control Measures	<b>Investigation of Contacts:</b> Provide treatment for sexual contact(s) on center; for off-center sexual contact(s), counsel student to have contact(s) seek treatment from STD clinic or physician.
	<b>Specific Treatment:</b> Consider oral acyclovir (200 mg) 5 times per day for 10 days or valacyclovir (1 gram) 2 times per day 10 days for initial episode of genital HSV infection. Advise student to use condoms during sexual activity.
Admission/Readmission	Not applicable.

TABLE 12	TABLE 12: CHLAMYDIAL INFECTIONS (Chlamydia Trachomatis)				
Identification	Genital infections, primarily urethritis in males and mucopurulent cervicitis in females. Similar to gonorrhea with opaque discharge, urethral itching, and burning on urination. Females may be asymptomatic. The infection may be concurrent with gonorrhea. Chlamydia also causes epididymitis in males, salpingitis (pelvic inflammatory disease) in females, and proctitis in either sex.				
Diagnosis	Non-gonococcal urethritis (NGU) or cervicitis based on failure to demonstrate Neisseria gonorrhea by smear and culture. Chlamydia etiology confirmed by cell culture, DNA probe, antigen detection, or fluorescent antibody staining.				
Transmission	Sexual contact.				
Incubation Period	5 to 10 days or longer. The period of communicability is unknown; reinfection is probably common.				
Preventive Measures	<ul> <li>Provide personal hygiene and health education regarding transmission of disease.</li> <li>Advise/encourage students to use condoms during sexual activity.</li> <li>Practice care in disposal of articles contaminated with urethral and cervical discharge.</li> </ul>				
Control Measures	<ul> <li>Reporting: Report to S/LHD, if required.</li> <li>Isolation: Practice drainage-secretion precautions for student in the infirmary.</li> <li>Immunization of Contacts: None.</li> <li>Investigation of Contacts: Provide treatment for sexual contact(s) on center; for off center sexual contact(s), counsel student to have contact(s) seek treatment from STD clinic or physician.</li> <li>Specific Treatment<sup>13</sup>: The infected student should be treated on center with azithromycin (1 gram) by mouth once or doxycycline (100 mg) by mouth, 2 times per day for 7 days.</li> </ul>				
Admission/Readmission	Not applicable.				

<sup>&</sup>lt;sup>13</sup>Note: Because gonococcal and chlamydia cervicitis are often difficult to distinguish clinically, treatment for both organisms is recommended when either is suspected.

TABLE 13: GONORRHEA				
	In females, initial urethritis or cervicitis occurs (usually mild), chronic endocervical infection is common, and in approximately 20 percent, there is uterine invasion at a future menstrual period with symptoms of endometritis, salpingitis, or pelvic peritonitis.			
Identification	In males, a purulent discharge from the anterior urethra with dysuria appears 2 to 7 days after exposure. Asymptomatic anterior urethral carriage may occur. Rectal infection may occur among homosexually active males. The infection may be concurrent with chlamydia.			
	Pharyngeal infection may occur in females and males.			
Diagnosis	wo techniques, gram stain and culture, generally can be considered liagnostic in males; they are highly suggestive in females, although ervical and anorectal cultures may be necessary to detect infection in emales. Gonococcal infection can also be confirmed by DNA probe and antigen detection techniques. Pharyngeal infection requires confirmation by culture.			
Transmission	Sexual contact.			
Incubation Period	Usually 2 to 7 days, sometimes longer.			
Preventive Measures	Provide personal hygiene and health education regarding transmission of disease.			
	Advise/encourage students to use condoms during sexual activity.			
	Reporting: Report to S/LHD, if required.			
	Isolation and Immunization of Contacts: None.			
Control Measures	<b>Investigation of Contacts:</b> Provide treatment for sexual contacts on center; for off center sexual contact(s), counsel student to have contact(s) seek treatment at STD clinic or physician.			
	<b>Specific Treatment:</b> The infected student should be treated on center with ceftriaxone, 250 mg IM in a single dose <b>or</b> cefixime 400 mg by mouth <b>or</b> ciprofloxacin, 500 mg orally in a single dose; plus doxycycline, 100 mg orally twice daily for 7 days. In the case of pregnant students administer ceftriaxone, 250 mg IM in a single dose. As a test for cure in pregnant students, repeat culture 14 days after treatment.			
Admission/Readmission	Not applicable.			

	TABLE 14: SYPHILIS
Identification	After an incubation period of 12 to 30 days, syphilis is characterized by a primary lesion (chancre), followed by fever and skin eruptions of various appearances. If left untreated, the cardiovascular and central nervous systems may be invaded.
Diagnosis	Usually made by serologic tests of blood and CSF when indicated. Positive tests with nontreponemal antigens should be confirmed by tests employing treponemal antigens.
Transmission	Primarily sexual contact, in the Job Corps age group.
Incubation Period	10 days to 3 months, usually 3 weeks.
Preventive Measures	Provide personal hygiene and health education regarding transmission of disease.
	Advise/encourage students to use condoms during sexual activity.
	Reporting: Report to S/LHD, if required.
	<b>Isolation:</b> Practice drainage-secretion precautions for student in the infirmary.
	Immunization of Contacts: None
Control Measures	<b>Investigation of Contacts:</b> Provide treatment for sexual contacts on center; for off-center sexual contact(s), counsel student to have contact(s) seek treatment from STD clinic or physician.
	<b>Specific Treatment:</b> The infected student should receive long-acting benzathine penicillin G, 2.4 million units IM on day of diagnosis. Serologic test should be repeated at 3 and 6 months to confirm adequate therapy. For penicillin-allergic students, either oral doxycycline, 100 mg twice daily for 14 days, or oral tetracycline, 500 mg four times daily for 14 days.
Admission/Readmission	Not applicable.

	TABLE 15: LYME DISEASE				
Identification	This tick-borne, spirochetal, zoonotic disease is characterized by a distinctive skin lesion, systemic symptoms, oligoarthritis, and neurologic and cardiac involvement occurring in varying degrees over a period of months to years.				
Diagnosis	Currently based on clinical findings, including a characteristic rash, and serological tests (which are poorly standardized) leading to variable results. Results may remain negative in persons treated early; test sensitivity increases markedly when patients progress to later stages.				
Transmission	Tick-borne; transmission does not occur until the tick has fed for several hours.				
Incubation Period	From 3 to 32 days after tick exposure.				
Preventive Measures	Education; avoid tick-infested areas, wear light-colored clothing, remove surface ticks every 3 to 4 hours, apply tick repellent.				
	Reporting: Most States require reporting to S/LHD.				
	Isolation: None				
	Immunization of Contacts: None				
Control Measures	Investigation of Contact(s): Only when a case occurs outside a recognized endemic focus.				
	<b>Specific Treatment:</b> Doxycycline (100 mg twice daily) for 14 to 21 days, or amoxicillin (500 mg three times per day) for 14 to 21 days, or cefuroxime axetil (500 mg twice per day) for 14 to 21 days. Later manifestations of the disease require longer courses of therapy.				
Admission/Readmission	Not applicable.				

## 6.0 MANAGEMENT OF IMMUNIZING AND OTHER BIOLOGICAL AGENTS

This section presents information on the purchasing, storage, administration, and disposal of immunizing agents.

#### 6.1 PURCHASE AND RECEIPT OF IMMUNIZING AGENTS

Immunizing agents generally should be procured from governmental sources. Some State and/or local health departments provide immunizing agents at no charge. This source should be investigated first. Commercial sources may be used when their prices are more economical than governmental sources or when urgently needed items are not immediately available from the Government. Government sources of supply are:

- U.S. Public Health Service, Supply Service Center, Perry Point, MD 21902
- Veterans Administration Supply Depot (134E), P.O. Box 27, Hines, IL 60141
- Defense Personnel Support System, 2800 South 20<sup>th</sup> Street, Philadelphia, PA 19101
- General Services Administration (GSA)<sup>14</sup>
- State and local health departments
- The Centers for Disease Control and Prevention

Catalogues are available from the above sources and contain all necessary ordering and shipping information.

In 1994, the Department of Health and Human Services implemented the Vaccines for Children (VFC) program that provides free vaccines to children who are on Medicaid, are without insurance or underinsured, or are Indian/Alaskan Natives. Many Job Corps youth may be eligible for this program. Centers are encouraged to contact their State/local health departments to determine vaccine availability under this program.

#### 6.2 STORAGE

The efficacy of vaccines and other immunization agents depends upon the integrity of the antigens, which they contain. Storage at improper temperatures may result in a rapid loss of potency and/or antigenicity. Thus, vaccines that have not been properly stored may not protect the recipients. For example, children vaccinated with live, attenuated measles vaccine that has been stored on refrigerator door shelves (where temperatures fluctuate) may not be protected and may develop clinical measles in later years. Therefore, it is essential that all vaccines be refrigerated (or frozen when this form of storage is recommended) immediately upon receipt, according to the manufacturer's instructions.

<sup>&</sup>lt;sup>14</sup>Orders should be placed with GSA Regional Office for the GSA region in which a center is located.

The following aspects of vaccine management are basic to a complete program. To ensure purity, potency, and unnecessary loss of vaccine, it is vitally important to follow prescribed rules.

- Follow the storage and handling instructions contained in the manufacturer's package inserts.
- Assign responsibility for vaccine storage management to one individual in each facility where vaccine stocks are kept.
- Monitor and maintain records of temperature readings of freezers and refrigerators at all times, including nights, holidays, and weekends. A telephone call list should be available in case of emergency.
- Never store vaccine on refrigerator door shelves.
- Maintain inventory control records that permit monitoring of individual lot numbers.
- Rotate vaccine stocks so as to use lots with the closest expiration dates first. <u>Never</u> <u>use outdated vaccine.</u>
- Establish an alert/notification system to make sure that vaccine shipments are expected and, if not received on schedule, the distributor is notified.
- Never store more vaccine than necessary, especially in areas with questionable monitoring capabilities.

#### 6.3 ADMINISTRATION

The Needlestick Safety and Prevention Act (PL 106-430), signed into law on November 6, 2000, requires employers to identify, evaluate, and implement safer medical devices. The Act also requires maintenance of a sharps injury log and mandates involvement of non-managerial healthcare workers in evaluating and choosing devices.

Requirements of this Act apply to all blood drawing, injections and immunizations administered on center [see PRH-5, Section 5.13 (R8)].

#### 6.4 DISPOSAL

Vaccines nearing the expiration date may be returned for credit or exchange if the manufacturer agrees to accept them. Otherwise, live vaccines must be autoclaved for 20 minutes, incinerated, or buried (e.g., sanitary landfill). Inactivated vaccines and toxoids should be disposed of as suggested by the manufacturer.

## 7.0 IMMUNIZATION RECORDS

Immunization records must be gathered and maintained for students participating in Job Corps. Immunization records are also maintained for personnel when indicated.

#### 7.1 IMMUNIZATION RECORD

#### 7.1.1 Initiation

The immunization record will be initiated at the time of initial vaccination of a student entering Job Corps or when a staff member is vaccinated for hepatitis B.

#### 7.1.2 Record Entries and Storage

Records of all immunizations of students will be entered on an immunization record. The immunization record will be filed in the student's health folder.

In accordance with the NCVIA, the date, name and title of the person administering the vaccine, date VIS was given, and name of the vaccine manufacturer and lot number must be recorded for each dose of the following vaccines:

- Measles-mumps-and rubella combination vaccines
- Diphtheria and tetanus toxoids
- Inactivated (injectable) polio vaccines
- Hepatitis B
- Influenza
- Varicella
- Hepatitis A
- Haemophilius influenzae type B
- Pneumococcal

#### 7.1.3 Copy of Immunization Record

Upon separation from Job Corps, each student should receive a copy of his/her immunization record.

#### 7.2 OTHER IMMUNIZATION RECORDS

#### 7.2.1 Records for Personnel Other than Students

Appropriate records will be maintained for center staff. Records of all staff hepatitis B immunizations will be recorded per the Exposure Control Plan requirements.

#### 7.2.2 Acceptance of Records of Prior Student Immunization

A written statement from a physician or an immunization record that is satisfactory to the center physician and attests to the immunization status of the individual by noting dates and doses is considered acceptable evidence of immunization [see Section 2.1.1]. This statement or record will be filed in the student's health folder.

# APPENDIX A JOB CORPS IMMUNIZATION FORMS

## **JOB CORPS IMMUNIZATION RECORD**

Name	Center

DOE\_\_\_\_\_ SSN\_\_\_\_\_ DOB\_\_\_\_\_

Agent		Date	Manufacturer Lot Number Expiration Date	Dose Route Injection Site	VIS Date*	Signature
Tetanus-Diphtheria Toxoid-Adult (Td)						
Inactivated Poliovirus Vaccine (IPV)						
Measles/	1					
Mumps/ Rubella (MMR)	2					
	1					
	2					
Hepatitis B Vaccine (HBV)	3					
	1st yr					
Influenza	2nd yr					
Others:						

\*Date vaccine information sheet (VIS) given to student/parent/legal guardian.

## **REACTIONS (use reverse as needed):**

## **PPD TESTING**

Name			Center				
DOB	_	DOE	SSN	SSN			
Has student ever had:	1. 2. 3.	Positive PPD skin test: Subsequent chest x-ray: Treatment with INH:		Date (Month/Year) Result (+/-) Duration (Months)			

Date of last x-ray and results

Date	Manufacturer Lot Number Expiration Date	Dose/Strength Route Injection Site	Signature	Date Read	Signature	Results in Millimeters
						ММ
						MM
						MM

Date(s) of x-rays/laboratory tests ordered and results:

Date	placed	on/not	placed c	on preventiv	e treatment	(circle one).	Specify	why not pla	aced on pre	eventive
treatn	nent.									

NOTE: Read reaction in 48-72 hours after injection Measure only induration Record results in millimeters Record as positive or negative per CDC guidelines Interpret without regarding to history of BCG vaccination

CLASSIFYING THE TUBERCULIN REACTION		
≥5mm is positive in:	<ul> <li>Students who are HIV positive</li> <li>Students who have had close contacts with persons with infectious TB</li> <li>Students who have a chest radiograph suggestive of previous TB</li> <li>Students with clinical evidence of tuberculosis</li> <li>Students who inject drugs</li> </ul>	
≥10mm is positive in:	<ul> <li>Students with certain medical conditions, excluding HIV infection</li> <li>Foreign-born students from areas where TB is common</li> <li>Medically underserved, low-income populations including high-risk racial and ethnic groups (including the homeless)</li> </ul>	
≥15mm is positive in:	All students with no known risk factors for TB	

Appendix A

Name			Center		
DOB	DOE		SSN		
Date INH started		Dosage/freq	uency: 300 mg daily <u>OR</u> 900 mg twice weekly		

Date other Rx started \_\_\_\_\_

Name/dosage/frequency \_\_\_\_\_

MONTH	WEEK/DATE (INITIALS)				

Symptoms: Fever/chills, fatigue, weakness, malaise, anorexia, stomach pain, nausea/vomiting, diarrhea, tingling/numbness fingers, dark urine/pale stools, yellowness of skin/eyes, rash/itching (note below with the date of onset)

Additional comments or tests ordered/results:

Date	
Date	
Date	

Date record closed

Reason for termination of chemoprophylaxis (check all that apply):

□ Completed treatment

- □ Non-compliant
- □ Toxicity
- □ AWOL
- □ Separation
- □ Other

Moved/Forwarding Address:

# APPENDIX B CDC VACCINE INFORMATION STATEMENTS

## **CDC VACCINE INFORMATION STATEMENTS**

Vaccine Information Statements (VISs) are produced by the Center for Disease Control and Prevention (CDC) that explain to vaccine recipients, their parent, or their legal representatives about the benefits and risks of a vaccine. They can be downloaded from <a href="https://www.cdc.gov/nip/publications/vis/default.htm">www.cdc.gov/nip/publications/vis/default.htm</a>.

VISs are available for:

- Diphtheria/Tetanus/Pertussis (DTaP)
- Hepatitis A
- Hepatitis B
- Haemophilus Influenzae type B (Hib)
- Influenza
- Lyme Disease
- Measles/Mumps/Rubella (MMR)
- Meningococcal
- Pneumoncoccal Polysaccharide
- Polio
- Tetanus/Diphtheria (Td)
- Varicella (Chickenpox)
- Anthrax

VISs are available in over 20 languages through the Immunization Action Coalition at <u>www.immunize.org/vis/index.htm</u>.

# APPENDIX C VACCINE ADVERSE EVENT REPORTING

## VACCINE ADVERSE EVENT REPORTING

The Vaccine Adverse Event Reporting System (VAERS), a cooperative program for vaccine safety of the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA), is a safety surveillance program collecting information about adverse events that occur after the administration of U.S. licensed vaccines.

VAERS encourages the reporting of any clinically significant adverse event that occurs after the administration of any vaccine licensed in the United States. You should report clinically significant adverse events even if you are unsure whether a vaccine caused the event. The VAERS form can be downloaded at <u>www.vaers.org/pdf/vaers\_form.pdf</u>.

The National Childhood Vaccine Injury Act (NCVIA) requires healthcare providers to report:

- Any event listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any event listed in the Reportable Events table that occurs within the specified time period after vaccination.

A copy of the Reportable Events Table can be obtained by calling VAERS at (800) 822-7967 or by downloading from <u>www.vaers.org/reportable.htm</u>.