STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
SECTION OF EPIDEMIOLOGY

3601 C STREET, SUITE 540
P.O. BOX 240249
ANCHORGE, ALASKA 99524-0249

FRANK H. MURKOWSKI, GOVERNOR

INFECTIOUS DISEASES
AIDS/STD
TUBERCULOSIS (907) 269-8000
IMMUNIZATION (907) 562-7802
CHRONIC DISEASES
DIABETES
INJURY CONTROL

June 16, 2004

Dear Alaska Immunization Provider:

The Alaska Immunization Program remains committed to supporting a universal vaccine distribution program to assure all Alaska children have the opportunity to receive adequate protection against vaccine-preventable diseases. To maintain this program in the future, however, we must increase our vaccine accountability requirements and emphasize methods to reduce vaccine wastage.

The numbers speak for themselves –

$6,000,000	Cost of vaccines the Alaska Immunization Program provided free-of-charge to Alaska providers during 2003
$500,000	Cost of vaccines wasted by Alaska providers in 2003 due to mishandling or expiration
$513	Cost for the Alaska Immunization Program to purchase all vaccines recommended for one child through school entry (see attachment for details)
$824	Cost for a private provider to purchase the same vaccines on the open market

Enclosed for your review and signature is the **2004/2005 Provider Certification Form** required by the Alaska Immunization Program for continued receipt of state-supplied vaccine. **PLEASE CAREFULLY READ THE REQUIREMENTS BEFORE SIGNING THE FORM.**

What's new?

- **Monthly vaccine ordering**
  - The formerly used quarterly ordering system increased the amount of vaccine stored in a refrigerator at any one time, so a larger amount of vaccine was lost if, for example, the refrigerator failed.
  - Monthly ordering applies to providers who routinely stock more than $1,000 of vaccine. Providers who maintain smaller vaccine inventories may simply order as needed.
- **Information required with each monthly order**
  - Current vaccine inventory
  - Vaccine Usage Report
  - Vaccine Wastage Report
  - Copy of current temperature logs for refrigerators/freezers used for main vaccine storage

Note: Please discard blank vaccine ordering, usage, and wastage reports dated prior to 06/10/2004.

- **Estimates of your client population by age group**
  - This information is required for Alaska's continued receipt of federally purchased vaccines and will be used to develop your anticipated monthly vaccine use.
  - The information will be maintained confidentially within the Immunization Program.

What's the same?

Continuing requirements and procedures are detailed on the enclosed *2004/2005 Alaska Vaccine Distribution Program Requirements*. **Please be sure to review all of the program requirements.**

The *Provider Certification Form* and the *Provider Survey* are the only materials that must be returned. All other forms and information sheets should be retained for your reference.

Please return the Form and Survey by **July 23, 2004** to:

Alaska Immunization Program - Vaccine Depot
9210 Vanguard Drive, Suite 102A
Anchorage, Alaska 99507

Attention: Debbie Wiegele
Phone: (907) 341-2202 **Fax:** (907) 341-2228

Please note: Vaccine orders received after *JULY 23, 2004* will be deferred until the 2004/2005 Physician Certification Form has been received.

Thank you for your immediate attention to these registration requirements and for your understanding of the need to increase Alaska's vaccine accountability. We appreciate your efforts to help ensure all Alaska children have ready access to vaccines at no charge to the patient.

Sincerely,

Laurel H. Wood
Immunization Program Manager

Enclosures:
1) The High Cost of Vaccinating One Child
2) Alaska Vaccine Distribution Program Requirements
3) 2004/2005 Provider Certification Form
4) Provider Survey
5) Countertop Display Sign
6) Vaccine Order Form
7) Vaccine Usage Report
8) Vaccine Return Form
9) Refrigerator/Freezer Temperature Logs
10) Planning for Vaccine Storage in the Event of a Power Failure
11) VAERS Forms
12) Vaccine Information Statements (VIS)

The High Cost of Vaccinating One Child through School Entry: Public *vs* Private Sector Purchase

Vaccine	# Doses Recommended thru School Entry	Public Sector Cost *(in dollars)*		Private Sector Cost *(in dollars)*	
		Per Dose	All Recommended Doses	Per Dose	All Recommended Doses
Pediarix *(DTaP/ Hep B/ Polio)*	3	35.48	106.44	70.72	212.16
Hepatitis B *(birth dose)*	1	9.50	9.50	21.37	21.37
DTaP	2	13.75	27.50	20.96	41.92
Polio	1	10.14	10.14	21.80	21.80
PedvaxHIB	3	9.95	29.85	22.77	68.31
MMR	2	16.25	32.50	36.84	73.68
PCV7	4	51.58	206.32	61.65	246.60
Varicella	1	48.00	48.00	60.69	60.69
Hepatitis A	2	11.50	23.00	26.66	53.32
Influenza	2¶	10.00	20.00	12.00	24.00
TOTAL	**21**		**$513.25**		**$823.85**

* Per National Immunization Program contract information (compiled 5/24/04)

¶ Children being vaccinated for the first time should receive 2 doses. Although additional doses of influenza may be recommended in subsequent years, only 2 doses are listed for the purposes of this analysis.

Revised 06/10/2004

2004/2005 Alaska Vaccine Distribution Program

Requirements

FEDERAL REQUIREMENTS

Under the provisions of Alaska's federal grant funding, providers who receive vaccine from the State Immunization Program are required to:

- Submit an annual **Provider Certification Form.**
- Provide vaccine recipients, their parent or legal representative with **Vaccine Information Statements (VIS)** explaining the risk and benefits of immunization.
- **Impose no charge for the cost of vaccines provided by the State.** If an administration fee is charged, prominently display information that indicates "No one may be denied vaccine provided through the Alaska Immunization Program for failure to pay the administration fee or failure to make a donation to the provider." (sample included in Packet)
- Follow Advisory Committee on Immunization Practices (ACIP), federal and state **recommendations** for the use of all vaccines purchased with federal funds.
- Ensure that **proper vaccine storage and handling procedures** are met. Allow inspection by the Alaska Immunization Program to monitor vaccine storage and handling practices.

STATE REQUIREMENTS

- Use state-supplied DT, DTaP, DtaP/IPV/hepatitis B combination, hepatitis A, hepatitis B, Hib, IPV, MMR, pneumococcal conjugate (PCV7), and varicella vaccines **ONLY for persons age 18 or younger**, except that these vaccines may be used for persons over age 18 if needed to meet Alaska school (grades K-12) immunization requirements.
- Develop (and display on main vaccine refrigerator) a vaccine emergency management plan to be used in the event of a power failure.
- Provide the patient, parent or guardian with a **personal record** of each immunization on an Alaska Immunization Record or other appropriate form.

Submit monthly reports, including:

- **Vaccine Order Form** - Based on previous usage, estimate the amount of vaccine required for a one-month period, and place one vaccine order per month. (Note: Monthly vaccine ordering requirements may be modified based on vaccine shortages.)
- **Vaccine Usage Report** - Submit monthly tabulations of vaccine doses administered, by antigen and age group.
- **Vaccine Return Form –** Return this form and ALL expired or spoiled vaccines to the Alaska Immunization Program on a monthly basis. (Alaska can obtain tax credits or rebates on many unused vaccines.)
- **Refrigerator/Freezer Temperature Logs** – Submit COPIES of temperature logs for all refrigerators/freezers used for main vaccine storage. Maintain the temperature logs and/or charts for a minimum of three years.

For varicella only, ensure that:

- the facility has a **freezer** (with a separate sealed freezer door) that reliably maintains an average temperature of **+5° F (–15° C) or colder**;
- facility staff receive **training** in the special handling requirements of varicella and the vaccine is stored and handled according to the product insert.

2004/2005 Alaska Vaccine Distribution Program

Provider Certification Form

Page 1 – General Registration

PLEASE PRINT OR TYPE

Facility Name _____

Immunization Contact for Facility _____

Shipping Address: _____

_____

_____

Mailing Address: (if different) _____

_____

_____

Phone No. _____ **Fax No.** _____

Email Address: _____

***Approximate* patient census in your facility, per age group:**

- Required for determination of anticipated monthly vaccine use
- Information will remain confidential within the Alaska Immunization Program

Under 1 yr _____ **1 – 6 yrs** _____ **7 – 18 yrs** _____ **19+ yrs** _____

Do you provide yellow fever vaccine? Yes No

If yes, please list your **Yellow Fever Authorization #:**

For providers <u>outside</u> the Anchorage area:

Is there any pertinent shipping information about which we should be aware?
(i.e., unusual clinic hours, delivery constraints, etc.)

_____

_____

2004/2005 Alaska Vaccine Distribution Program

Provider Certification Form

Page 2 – Certification

As a condition for receiving vaccines from the Alaska Department of Health & Social Services, I/we have read the Federal/State Requirements for the use of state-supplied vaccine and agree to the following terms:

1. I certify that, in administering vaccine received from the Alaska Immunization Program for use in my practice, **I will provide patients/parents/guardians a copy of the currently approved "Vaccine Information Statement" (VIS) before administering each dose of vaccine.** I will record the following information in the patient's medical record:

   Date vaccine administered;
   Manufacturer name and **lot number** of the vaccine;
   Signature and professional title of person administering the vaccine;
   Address of facility in which the vaccine is administered;
   Printing Date of VIS.

2. I will **charge no patient, parent, legal guardian, or third party a fee for the cost of the vaccine** received from the Alaska Immunization Program. I recognize that I may charge a nominal administration fee. However, **clients will not be denied state-supplied vaccine due to inability to pay an administrative fee.** I will post a public sign in my office stating this policy.

3. I will submit **monthly reports** to the Alaska Immunization Program office, including:
   - Vaccine Order Form
   - Vaccine Usage Report
   - Vaccine Return Form
   - Copies of Temperature Logs from main refrigerator/freezer used for vaccine storage

   I understand that, if the designated reports do not accompany my vaccine order, the order will not be filled.

4. I will **return all spoiled or expired vaccine** (including partial vials) to the Alaska Immunization Program along with the completed *Vaccine Return Form.*

5. I will ensure that all **vaccines are maintained at the appropriate temperatures** as published in the vaccine product insert. I will ensure that vaccine storage temperatures are monitored and recorded twice daily and that refrigerator/freezer temperature logs are maintained for a minimum of **three years**.

6. I will, in accordance with Federal requirements, allow the Alaska Immunization Program access to my office for the purpose of monitoring vaccine storage and handling practices.

7. ***(For varicella vaccine only)*** I will ensure that:

   a. my facility has a **freezer** (with a separate, sealed freezer door) that reliably will maintain an average temperature of +5° F (–15° C) or colder;

   b. facility staff are instructed in the **special handling requirements** of varicella vaccine and the vaccine will be stored and handled according to the product insert.

→ **I understand and accept the terms outlined above. I agree to ensure that all medical personnel who administer state-supplied vaccine under my supervision understand and agree to these requirements.**

Physician/ Advanced Nurse Practitioner Representing Facility ***(Signature)***	Physician/ Advanced Nurse Practitioner Representing Facility ***(Please Print)***	Date

Alaska Medical License No.	Medicaid Provider No.

Important: List names and numbers for associate MDs/ANPs in the facility on the following page.

2004/2005 Alaska Vaccine Distribution Program

Provider Certification Form

Page 3 – Associate Providers in Facility

Facility Name:

Please list associate physicians/ advanced nurse practitioners in the facility:

Print or Type:

Name	AK Medical License #	Medicaid Provider #

(please copy this page if additional space is needed)

Alaska Immunization Program

2004/2005 Provider Survey

Name: _____

Facility: _____

Questions about the Alaska Vaccine Distribution Program

1. How easy do you find it to place a vaccine order with the AK Vaccine Distribution Program?

❑ Easy ❑ Relatively Easy ❑ Slightly Difficult ❑ Fairly Difficult ❑ Very Difficult

2. Are you treated courteously when you call to ask questions or check on an order?

❑ Always ❑ Usually ❑ Occasionally ❑ Rarely ❑ Never

3. Do you receive your vaccines *(or an explanation about vaccines which must be back-ordered)* within three weeks of placing the order?

❑ Always ❑ Usually ❑ Occasionally ❑ Rarely ❑ Never

4. How frequently are you told the vaccines you need are unavailable and must be back-ordered?

❑ Always ❑ Usually ❑ Occasionally ❑ Rarely ❑ Never

5. Are your vaccine orders filled correctly *(i.e., do you receive the number and type of vaccines you ordered)*?

❑ Always ❑ Usually ❑ Occasionally ❑ Rarely ❑ Never

6. How easy is it to use the form to place orders?

❑ Easy ❑ Relatively Easy ❑ Slightly Difficult ❑ Fairly Difficult ❑ Very Difficult

7. How easy is it to use the form to report monthly vaccine use?

❑ Easy ❑ Relatively Easy ❑ Slightly Difficult ❑ Fairly Difficult ❑ Very Difficult

Questions about the TOTAL Alaska Immunization Program **(more than just vaccine distribution)**

8. Have you ever called the Alaska Immunization Program to obtain technical consultation about vaccines or vaccine scheduling? ❑ Yes ❑ No

If yes, was/were your question(s) answered correctly and in a timely manner?

❑ Always ❑ Usually ❑ Occasionally ❑ Rarely ❑ Never

9. In general, how would you rate the services of the Alaska Immunization Program?

❑ Excellent ❑ Above Average ❑ Average ❑ Needs Improvement ❑ Poor

Do you have any suggestions for improving the program or anything else you would like to tell us?

_____

_____

_____

(may continue on back of this page)

Fold in half, and place on countertop

No one may be denied vaccine provided through the Alaska Immunization Program for failure to pay an administration fee or failure to make a donation to the provider.

Vaccine Order Form
Alaska Department of Health and Social Services

Immunization Program Vaccine Depot
9210 Vanguard Drive - Suite 102A
Anchorage, Alaska 99507
Telephone: (907) 341-2202 FAX: (907) 341-2228

- **Please order your vaccine supplies MONTHLY.** Receiving smaller orders allows us to improve our inventory control and reduce vaccine wastage.
- The *Vaccine Usage Report, Vaccine Return Form* and COPIES of current temperature logs from main vaccine storage units must be submitted with every *Vaccine Order Form.*
- Please allow **three (3) weeks** for delivery.

Facility Name *(required)* : **(Please use the same Facility Name each time you place an order.)**

Address *(required)* :

Telephone *(required)* : **FAX:**

Person Completing Form *(required)* : **E-mail Address:**

Date: _____ / _____ / _____ **Note: Anchorage-vicinity providers will be notified when their orders are ready for pick up.**

Vaccine / Testing Material	Current Vaccine Inventory*	Doses Ordered	Total Vaccine Usage, by antigen (from "Total" column on Usage Report)	Vaccine Returned, by antigen (from Vaccine Returned Rpt)	for office use only	
					Doses Filled	Lot #
DT (Ped)						
DTaP						
DTaP / Hep B/ IPV (combination)						
Hepatitis A (Ped)						
Hepatitis B (Ped)						
Hib						
Influenza						
IPV						
MMR & diluent						
Pneumococcal Conjugate (PCV7)						
Pneumococcal Polysaccharide (PPV23)						
PPD						
Td (Adult)						
Typhoid (limited availability)						
Varicella & diluent (shipped directly from mfr)						
Yellow Fever (available only for approved public health ctrs)						
Other:						
Other:						

*** Inventory required for ALL vaccines (not just those being ordered today)**

STATE-SUPPLIED VACCINE USAGE REPORT

AGE-SPECIFIC DOSES ADMINISTERED

Facility Name:

Address:

Telephone: Person Completing Report:

E-mail Address:

Year: _____

Month: _____

On the appropriate line designated for each vaccine, enter the total number of doses given according to the age groups indicated.
Please DO NOT use hash marks. Use additional copies for worksheets.

Vaccine Type	TOTAL DOSES GIVEN, BY PATIENT AGE-GROUP													
	<1	1	2	3 to 5	6	7 to 10	11 to 12	13 to 18	19 to 24	25 to 44	45 to 64	65+	UNKNOWN	TOTAL
☹ **INCORRECT Example**		IIII	II	卌	卌 卌								0	21
☺ **CORRECT Example**	0	4	2	5	10								0	21
DT (Ped)														
DTaP														
DTaP/Hep B/IPV (combination)														
Hepatitis A (Ped)														
Hepatitis B (Ped)														
Hepatitis B / Hib (combination)														
Hib														
Influenza (preservative-free)														
Influenza (with preservative)														
IPV (Polio)														
MMR														
Pneumococcal Conj. (PCV7)														
Pneumococcal Poly. (PPV23)														
Td (Adult)														
Typhoid														
Varicella														
Yellow Fever														
Other: _____														
Other: _____														

This report is to be submitted each month with the *Vaccine Order Form* and the *Vaccine Return Form*.

Alaska Department of Health and Social Services
Immunization Program Vaccine Depot
9210 Vanguard Drive - Suite 102A
Anchorage, Alaska 99507
(907) 341-2202 FAX: (907) 341-2228

Vaccine Return Form
(for State-Supplied Vaccines only)

Alaska Department of Health and Social Services
Immunization Program Vaccine Depot
9210 Vanguard Drive – Suite 102A
Anchorage, Alaska 99507

(907) **341-2202** **FAX:** (907) **341-2228**

Facility Name: _____

Address: _____

Person Completing Form: _____

Phone: _____

Date: _____

Instructions: Please enclose this form with your *Monthly Order Form* AND include a COPY when the vaccines are physically returned. Mail spoiled/outdated vaccines to the address above. ***To return viable vaccines you must call the Vaccine Depot for shipping instructions.***

Return Codes:
- **2** – Short-dated
- **3** – Spoiled
- **4** – Expired
- **5** – Lost or damaged in transit
- **7** – Refrigerator failure

Vaccine	Lot #	# of Doses	Return Code *(see above)*	Brief explanation of circumstances causing return
DT (Ped)				
DTaP				
DTaP/ Hep B/ IPV (combination)				
Hepatitis A (Ped)				
Hepatitis B (Ped)				
Hep B/Hib (combination)				
Hib				
Influenza				
IPV				
MMR				
Pneumococcal Conjugate (PCV7)				
Pneumococcal Polysaccharide (PPV23)				
PPD				
Td (Adult)				
Typhoid				
Varicella				
Yellow Fever				
Other:				
Other:				

Protect Your Vaccines. Check Temperatures Twice a Day!

Mo/Yr _____ **DAYS 1-15**

Instructions: Insert the day, time, and your initials in the designated boxes. Then place an "X" in the box that corresponds to your temperature reading.

THE SHADED ZONES REPRESENT UNACCEPTABLE TEMPERATURES! IF A TEMPERATURE IS RECORDED IN THIS AREA:

1. Store the vaccine under proper conditions as quickly as possible. (Be sure to segregate the vaccine and identify it as "DO NOT USE" while vaccine viability is being determined.)
2. Call the **Alaska Immunization Program (341-2202)** to determine whether the potency of the vaccine has been affected.
3. If the vaccine is found to be viable, return it to a working refrigerator/freezer. Unviable vaccine should be returned to the AK Immunization Program with a "Vaccine Return Form."

Day of Month	1		2		3		4		5		6		7		8		9		10		11		12		13		14		15	
Day of Week																														
Time of Day	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm
Staff Initials																														
REFRIGERATOR (F°) ≥49°																														
48°									**DO NOT USE vaccines that have been stored at these temperatures! See instructions at top of page.**																					
47°																														
46°																														
45°																														
44°																														
43°																														
42°																														
41°																														
40°																														
39°																														
38°																														
37°																														
36°																														
35°																														
34°																														
33°																														
32°									**DO NOT USE vaccines that have been stored at these temperatures! See instructions at top of page.**																					
31°																														
≤30°																														
FREEZER (F°) >8°																														
7°							***Note:* Frost-free freezers will rise above 5°F for *short* periods of time during the day. This is normal and acceptable for vaccine storage.**																							
6°																														
5°																														
4°																														
≤3°																														

Remember: Use the "Action Taken" form to document activities affecting vaccine

Protect Your Vaccines. Check Temperatures Twice a Day! **Mo/Yr** _____ **DAYS 16-31**

Instructions: Insert the day, time, and your initials in the designated boxes. Then place an "X" in the box that corresponds to your temperature reading.

THE SHADED ZONES REPRESENT UNACCEPTABLE TEMPERATURES! IF A TEMPERATURE IS RECORDED IN THIS AREA:

1. Store the vaccine under proper conditions as quickly as possible. (Be sure to segregate the vaccine and identify it as "DO NOT USE" while vaccine viability is being determined.)
2. Call the **Alaska Immunization Program (341-2202)** to determine whether the potency of the vaccine has been affected.
3. If the vaccine is found to be viable, return it to a working refrigerator/freezer. Unviable vaccine should be returned to the AK Immunization Program with a "Vaccine Return Form."

Day of Month	16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
Day of Week																																
Time of Day	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm
Staff Initials																																
≥49°																																
48°																																
7°																																
46°																																
45°																																
REFRIGERATOR (F°) 44°																																
43°																																
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34°																																
33°																																
32°																																
31°																																
≤30°																																
FREEZER (F°) >8°																																
7°																																
6°																																
5°																																
4°																																
≤3°																																

DO NOT USE vaccines that have been stored at these temperatures! See instructions at top of page.

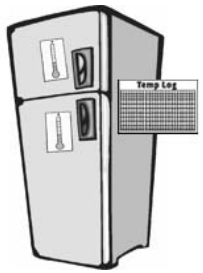
Note: **Frost-free freezers will rise above 5°F for *short* periods of time during the day. This is normal and acceptable for vaccine storage.**

DO NOT USE vaccines that have been stored at these temperatures! See instructions at top of page.

Remember: Use the "Action Taken" form to document activities affecting vaccine

Refrigerator/Freezer Location _____

(maintain this form with this unit)



Action Taken

Use this form to document any action you've taken to adjust refrigerator/freezer temperature, move vaccine to another unit, etc.

Date	Time (include a.m. or p.m.)	Brief Description of Problem	Action Taken

2004/2005 Alaska Vaccine Distribution Program

Planning for Vaccine Storage in the Event of a Power Failure

→ **Please make plans now for safekeeping of your vaccine in the event of a power failure, including potentially transporting vaccine to alternate storage sites.**

As a vaccine provider in Alaska, you receive vaccines at no cost to you. However, these vaccines are quite expensive. At any given time, even a small clinic may have several thousand dollars worth of vaccine in the refrigerator. Therefore:

- **Every vaccine provider must ensure written emergency procedures are in place that will maintain your vaccine supply at proper storage temperatures in the event of power outages.** Assurances might include having your own back-up generators or a written plan to transport vaccines to alternate storage facilities (such as local hospitals or police/fire stations) that have emergency power systems and appropriate refrigerator/freezer units.

- **Written emergency procedures must be posted in a highly visible location** (such as on the door of the main vaccine storage refrigerator) so that they may be easily located in the event of a power failure.

- Persons responsible for vaccine storage should ensure availability of **staff** and an adequate supply of **coolers and cold packs** to transport vaccine.

Thank you for your attention to the care of your vaccines. If you have any questions or comments about vaccine storage and handling, contact:

Alaska Immunization Program Vaccine Depot

DURING OFFICE HOURS: (907) 341-2202

AFTER HOURS: in Anchorage 269-8000 outside Anchorage 1-800-478-0084

VACCINE ADVERSE EVENT REPORTING SYSTEM

24 Hour Toll-Free Information 1-800-822-7967
P.O. Box 1100, Rockville, MD 20849-1100
PATIENT IDENTITY KEPT CONFIDENTIAL

For CDC/FDA Use Only

VAERS Number _____

Date Received _____

Patient Name:

Last First M.I.

Address

City State Zip

Telephone no. (____) _____

Vaccine administered by (Name):

Responsible Physician _____

Facility Name/Address

City State Zip

Telephone no. (____) _____

Form completed by (Name):

Relation to Patient ☐ Vaccine Provider ☐ Patient/Parent ☐ Manufacturer ☐ Other

ATT'N VAERS STAFF
Send VAERS number to:
AK Immunization Program
3601 C Street, Suite 540
Anchorage, AK 99503-5932
Phone: (907) 269-8000

1. State

2. County where administered

3. Date of birth ___/___/___ (mm dd yy)

4. Patient age

5. Sex ☐ M ☐ F

6. Date form completed ___/___/___ (mm dd yy)

7. Describe adverse events(s) (symptoms, signs, time course) and treatment, if any

8. Check all appropriate:
- ☐ Patient died (date ___/___/___ (mm dd yy))
- ☐ Life threatening illness
- ☐ Required emergency room/doctor visit
- ☐ Required hospitalization (_____days)
- ☐ Resulted in prolongation of hospitalization
- ☐ Resulted in permanent disability
- ☐ None of the above

9. Patient recovered ☐ YES ☐ NO ☐ UNKNOWN

10. Date of vaccination ___/___/___ (mm dd yy) Time _____ AM PM

11. Adverse event onset ___/___/___ (mm dd yy) Time _____ AM PM

12. Relevant diagnostic tests/laboratory data

13. Enter all vaccines given on date listed in no. 10

	Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous Doses
a.					
b.					
c.					
d.					

14. Any other vaccinations within 4 weeks prior to the date listed in no. 10

	Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous doses	Date given
a.						
b.						

15. Vaccinated at:
- ☐ Private doctor's office/hospital
- ☐ Public health clinic/hospital
- ☐ Military clinic/hospital
- ☐ Other/unknown

16. Vaccine purchased with:
- ☐ Private funds
- ☐ Public funds
- ☐ Military funds
- ☐ Other/unknown

17. Other medications

18. Illness at time of vaccination (specify)

19. Pre-existing physician-diagnosed allergies, birth defects, medical conditions (specify)

20. Have you reported this adverse event previously? ☐ No ☐ To health department ☐ To doctor ☐ To manufacturer

21. Adverse event following prior vaccination (check all applicable, specify)

	Adverse Event	Onset Age	Type Vaccine	Dose no. in series
☐ In patient				
☐ In brother or sister				

Only for children 5 and under

22. Birth weight _____ lb. _____ oz.

23. No. of brothers and sisters

Only for reports submitted by manufacturer/immunization project

24. Mfr./imm. proj. report no.

25. Date received by mfr./imm.proj.

26. 15 day report? ☐ Yes ☐ No

27. Report type ☐ Initial ☐ Follow-Up

Health care providers and manufacturers are required by law (42 USC 300aa-25) to report reactions to vaccines listed in the Table of Reportable Events Following Immunization. Reports for reactions to other vaccines are voluntary except when required as a condition of immunization grant awards.

SEND COMPLETED FORM TO:

AK Immunization Program
Section of Epidemiology
3601 C Street, Suite 540
Anchorage, AK 99503-5932

DIRECTIONS FOR COMPLETING FORM

(Additional pages may be attached if more space is needed.)

GENERAL

- Use a separate form for each patient. Complete the form to the best of your abilities. Items 3, 4, 7, 8, 10, 11, and 13 are considered essential and should be completed whenever possible. Parents/Guardians may need to consult the facility where the vaccine was administered for some of the information (such as manufacturer, lot number or laboratory data.)
- Refer to the Reportable Events Table (RET) for events mandated for reporting by law. Reporting for other serious events felt to be related but not on the RET is encouraged.
- Health care providers other than the vaccine administrator (VA) treating a patient for a suspected adverse event should notify the VA and provide the information about the adverse event to allow the VA to complete the form to meet the VA's legal responsibility.
- These data will be used to increase understanding of adverse events following vaccination and will become part of CDC Privacy Act System 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems". Information identifying the person who received the vaccine or that person's legal representative will not be made available to the public, but may be available to the vaccinee or legal representative.
- Postage will be paid by addressee. Forms may be photocopied (must be front & back on same sheet).

SPECIFIC INSTRUCTIONS

Form Completed By: To be used by parents/guardians, vaccine manufacturers/distributors, vaccine administrators, and/or the person completing the form on behalf of the patient or the health professional who administered the vaccine.

Item 7: Describe the suspected adverse event. Such things as temperature, local and general signs and symptoms, time course, duration of symptoms, diagnosis, treatment and recovery should be noted.

Item 9: Check "YES" if the patient's health condition is the same as it was prior to the vaccine, "NO" if the patient has not returned to the pre-vaccination state of health, or "UNKNOWN" if the patient's condition is not known.

Item 10: and 11: Give dates and times as specifically as you can remember. If you do not know the exact time, please indicate "AM" or "PM" when possible if this information is known. If more than one adverse event, give the onset date and time for the most serious event.

Item 12: Include "negative" or "normal" results of any relevant tests performed as well as abnormal findings.

Item 13: List ONLY those vaccines given on the day listed in Item 10.

Item 14: List any other vaccines that the patient received within 4 weeks prior to the date listed in Item 10.

Item 16: This section refers to how the person who gave the vaccine purchased it, not to the patient's insurance.

Item 17: List any prescription or non-prescription medications the patient was taking when the vaccine(s) was given.

Item 18: List any short term illnesses the patient had on the date the vaccine(s) was given (i.e., cold, flu, ear infection).

Item 19: List any pre-existing physician-diagnosed allergies, birth defects, medical conditions (including developmental and/or neurologic disorders) for the patient.

Item 21: List any suspected adverse events the patient, or the patient's brothers or sisters, may have had to previous vaccinations. If more than one brother or sister, or if the patient has reacted to more than one prior vaccine, use additional pages to explain completely. For the onset age of a patient, provide the age in months if less than two years old.

Item 26: This space is for manufacturers' use only.

2004/2005 Alaska Vaccine Distribution Program

Vaccine Information Statements (VIS)

→ Please discard all VIS with Revision Dates prior to those listed ←

VIS	Current Revision Date
Chickenpox (Varicella)	12/16/98
Diphtheria, Tetanus, and Pertussis (DTaP)	07/30/01
Hepatitis A	08/25/98
Hepatitis B	07/11/01
Haemophilus influenzae type b (Hib)	12/16/98
Influenza (most current version sent w/ state-supplied vaccine orders)	05/24/04
Polio (IPV)	01/01/00
Measles, Mumps, and Rubella (MMR)	01/15/03
Pneumococcal Conjugate (PCV7)	09/30/02
Pneumococcal Polysaccharide (PPV23) **AK specific VIS***	07/25/03*
Tetanus and Diphtheria (Td)	06/10/94

If a VIS is not available for a non-routine combination vaccine (e.g., DTaP/Hep B/IPV), use the appropriate VIS for all component vaccines.

VIS Websites:

http://www.cdc.gov/nip/publication/VIS

Includes camera-ready versions of all national VIS.

* Note: Contact the Alaska Immunization Program Vaccine Depot (341-2202) for a camera-ready copy of the **Alaska-specific** VIS for pneumococcal polysaccharide vaccine PV23.

http://www.immunize.org

Includes VIS translations in a variety of foreign languages.