COVID VACCINE CLINIC
ANAPHYLACTIC REACTION EMERGENCY
PROTOCOL

I. GENERAL GUIDELINES

A. PURPOSE

To respond immediately and give appropriate treatment to a patient who exhibits symptoms of an anaphylactic reaction including a patient who has been administered an immunizing agent. Anaphylaxis is a serious medical emergency.

B. GENERAL INFORMATION

Anaphylaxis is defined as a serious allergic or hypersensitivity reaction that is rapid in onset and may cause death. The rapid recognition and immediate management by medical and nursing personnel are critical. The goal of therapy is early recognition and treatment with epinephrine to prevent progression to life-threatening respiratory and/or cardiovascular symptoms and signs, including shock.

Emergency care equipment must be present and available for immediate use <u>before</u> immunizations are given. Check emergency kit to make sure epinephrine and Benadryl / Diphenhydramine are not outdated on a monthly basis or sooner as determined by the site's medical supervisor and it will be the responsibility of the medical supervisor to make sure this task is completed. Documentation of the emergency equipment supplies will occur on the table provided below. Items not applicable will be marked as "N/A".

1. The Medical Director over the COVID programs is responsible for the medical supervision of the immunization program. The Medical Director, or appropriate designee, will be immediately available during the hours of immunization administration. Immunizations must be administered in an area with immediate access to a telephone.

2. Preventive measures
    a. Beware of the dangers of anaphylactic reactions
    b. Know the symptoms
    c. Ask about previous reactions to immunizing agents and injectable medications and about history of anaphylaxis to medications, foods, pollens, bee stings, etc. before giving immunization.

3. Symptoms and Signs of Anaphylaxis:
    - **Skin:**
      Feeling of warmth, flushing (erythema), itching, urticaria, angioedema, and "hair standing on end" (piloerection)
    - **Oral:**
      Itching or tingling of lips, tongue, or palate
      Edema of lips, tongue, uvula, metallic taste
    - **Respiratory:**
      Nose – Itching, congestion, rhinorrhea, and sneezing
      Laryngeal – Itching and "tightness" in the throat, dysphonia, hoarseness, stridor
    - **Gastrointestinal:**
      Nausea, abdominal pain, vomiting, diarrhea, and dysphagia (difficulty swallowing)
    - **Cardiovascular:**

Feeling of faintness or dizziness; syncope, altered mental status, chest pain, palpitations, tachycardia, bradycardia or other dysrhythmia, hypotension, tunnel vision, difficulty hearing, urinary or fecal incontinence, and cardiac arrest.

- **Neurologic:**
  Anxiety, apprehension, sense of impending doom, seizures, headache and confusion; young children may have sudden behavioral changes (cling, cry, become irritable, cease to play)
- **Ocular:**
  Periorbital itching, erythema and edema, tearing, and conjunctival erythema
- **Other:**
  Uterine cramps in women and girls

C. PRECAUTIONS

1. Preparation for all emergencies is impossible, but pre-planning to meet the emergency is essential.
2. Check emergency supplies and emergency response role before each clinic.

D. PERSONNEL

1. School Nurse or Nurse Practitioner
2. School Physician
3. Medical Assistant under the direct supervision of a Nurse Practitioner or Physician

E. EQUIPMENT (available for immediate use)

All clinical areas where biologicals are to be injected will have emergency medications / equipment on site that will include the following items:

1. Aqueous Epinephrine Hydrochloride (Adrenaline) 1:1000 solution (or appropriate doses of Epinephrine auto-injectors - 0.10 mg, 0.15 mg and 0.30 mg each per dose, dependent on patient population served)
2. Diphenhydramine Hydrochloride (Benadryl) injectable 50 mg/ml
3. Tuberculin (TB) syringe-non retractable (or appropriate available alternative)
4. 25 gauge 1” safety glide needle
5. Cold packs
6. Sphygmomanometer (infant, child, adult and/or large adult cuff as appropriate for population being served)
7. Stethoscope
8. Disposable vinyl gloves
9. Cotton balls
10. Alcohol or Alcohol prep pads
11. Sharps container

II. PROCEDURE

ESSENTIAL STEPS	KEY POINTS AND PRECAUTIONS

1. Determine that patient has symptoms of anaphylactic reaction. **Call "911".**	When in doubt, treat as a serious allergic reaction. CALL PARAMEDICS, **AND** 1) the Medical Director or designee 2) the school administrator, and 3) parent (as appropriate) **Never leave patient unattended**
2. Check, monitor and maintain the patient's airway.	Do not leave patient unattended
3. Lay the patient flat with feet elevated. If dyspneic or vomiting, place the patient semi recumbent with lower extremities elevated.	Position vomiting patient to insure patient will not aspirate
4. Prepare appropriate amount/dose*** of Epinephrine (Adrenaline 1:1000) (See table below and instructions below) or use 0.10 mg or 0.15 mg or 0.30 mg epinephrine auto-injector, follow manufacturer instructions and skip "a" and "b" below.** a. Cleanse top of epinephrine vial with alcohol pad b. Attach 25 gauge 1" needle to TB syringe (or appropriate alternative) c. Draw up required epinephrine dose into syringe or use appropriate dose auto injector as indicated in Epinephrine Dose Chart below (also Attachment A). d. Inject epinephrine dose intramuscularly e. Assess need for second dose of epinephrine in 5 -15 minutes f. Draw up / administer second dose of epinephrine per Epinephrine Dose Chart below (also Attachment A) if needed.	If appropriate, cleanse injection site with cotton ball soaked in alcohol or alcohol prep pad. If necessary, secure assistance to immobilize site to be injected. Administer injection **INTRAMUSCULARLY**, (into the mid-outer aspect of the thigh if available). ***Never administer by intravenous route***. Patient should respond within 5 – 10 minutes. Alert patient to expected response to epinephrine (anxiety, headache, fear, palpitations, restlessness, tremor, weakness, dizziness, respiratory difficulty) A second dose of epinephrine may be given in 5- 15 minutes after the first, if symptoms have not subsided, or if response is inadequate and paramedics have not arrived. ******DO NOT ADMINISTER SECOND DOSE OF EPI IN SAME SITE AS FIRST DOSE. IT MAY CAUSE NECROSIS.

ESSENTIAL STEPS	KEY POINTS AND PRECAUTIONS

First-Line Treatment: ***Epinephrine***
(recommended dose for epinephrine is 0.01 mg/kg body weight)

Age Group	Weight Range (lb.)	Weight Range (kg)*	Epinephrine Dose 1 mg/ml injectable (1:1000 dilution) Intramuscular	Auto-Injector Dose (0.10 mg or 0.15 mg or 0.30 mg per dose)
Infants & Children			Minimum dose: 0.05 ml	
1 - 6 months	9 - 19 lb.	4 - 8.5 kg	0.05 mL	N/A
7 - 36 months	20 - 32 lb.	9 - 14.5 kg	0.10 mL	0.10 mg
37 - 59 months	33 - 39 lb.	15 - 17.5 kg	0.15 mL	0.15 mg
5 - 7 years	40 - 56 lb.	18 - 25.5 kg	0.20 - 0.25 mL	0.15 mg
8 -10 years	57 - 76 lb.	26 - 34.5 kg	0.25 - 0.30 mL	0.30 mg
11 - 12 year	77 - 99 lb.	35 - 45 kg	0.35 - 0.40 mL	0.30 mg **Teens /**
13 years & older	100 + lb.	46 + kg	0.50 mL	0.30 mg **Adults**

Note: If body weight is known, then dosing by weight is preferred. If weight is not known or not readily available, dosing by age is appropriate.
*Rounded weight at the 50th percentile for each age range.
Maximum dose for children: Dose according to chart, max of 3 injections, 5-15 min apart Maximum dose for teens/adults: 0.5ml/injection, max of 3 injections, 5-15 min apart

5. Place covered cold pack over vaccine injection site.	Have someone else do this if necessary. The cold pack delays absorption of vaccine
6. Monitor vital signs: a. Maintain adequate airway b. Employ CPR if needed	Monitor and record vital signs, including blood pressure and pulse, every 5 minutes.
7. Assess for presence of itching and hives. If present, prepare and administer Diphenhydramine (Benadryl) **intramuscularly** per Diphenhydramine Dose Chart Below (also Attachment A).	Benadryl (50 mg/mL) can be given in addition to epinephrine to relieve itching and hives. Administer once **INTRAMUSCULARLY** (<u>at site other than the epinephrine</u>) according to dosage table. **<u>DO NOT REPEAT</u>**

Secondary Treatment Option: *Diphenhydramine*
(the recommended dose for the diphenhydramine *(Benadryl*) is 1-2 mg/kg body weight) Diphenhydramine Dose

Age Group	Range of Weight (lb)	Range of Weight (kg)*	50 mg / ml injectable (IV or IM)
Infants and Children	7 - 36 months	20 - 32 lb	9 - 14.5 kg	10 mg - 15 mg / dose (0.20 - 0.30 ml)
	37 - 59 months	33 - 39 lb	15 - 17.5 kg	15 mg - 20 mg / dose (0.30 - 0.40 ml)
	5 - 7 years	40 - 56 lb	18 - 25.5 kg	20 mg - 25 mg / dose (0.40 - 0.50 ml)
	8 - 12 year	57 - 99 lb	26 - 45 kg	25-50mg (0.50 ml -1 ml)
Teens / Adults	13 years & older	100 + lb	46 + kg	50 mg / dose (1.0 ml)

Note: If body weight is known, then dosing by weight is preferred. If weight is not known or not readily available, dosing by age is appropriate.
*Rounded weight at the 50th percentile for each age range.
Maximum dose for: 1-2 mg/kg. ***Do not repeat initial dose.***
***Although commonly used, data supporting the role or effectiveness of second-line treatment options (Benadryl) in the management of anaphylaxis are limited. Hence, these second-line treatments should be considered only as adjunct therapy to epinephrine.*

8. Continue to monitor the patient until the paramedics arrive or as advised by the Medical Director or designee.	Observe patient until transferred to hospital. Send/take all appropriate patient emergency information with the patient when transported to nearest emergency room. *If you used an **AED, DO NOT SEND IT TO HOSPITAL WITH PARAMEDICS*** ***If parent or guardian is not present, District personnel must accompany a minor.**
9. Dispose of waste materials.	"Universal Precautions" requires that all contaminated waste material be double-bagged or bagged in Red Bag, specifically designated for contaminated material. Used needles and syringes are placed into sharp containers.
10. Remove gloves if used and wash hands.	

ESSENTIAL STEPS	KEY POINTS AND PRECAUTIONS

11. Record procedure for transfer of information onto VAERS.	Record the incident in VAERS, including, but not limited to: a. Date and time of incident. b. Symptoms indicating need for initiating anaphylaxis procedures. c. Times, dosage, and site of medication given d. Vital signs. Include all blood pressure readings and times e. Patient's response f. Medical Director's or designee's order/notification. g. Time and place patient was transported by paramedics and who accompanied (if applicable, parent, guardian, District personnel, etc.)
Report an Adverse Event to VAERS Online or Report Using a PDF Form	If you need further assistance with reporting to VAERS, please email info@VAERS.org or call 1-800-822-7967.

APPROVED: January 25, 2021
Date

_____

Murray Lappe, MD
Medical Director, COVID Vaccine Program

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Attachment A

Medical Management of Vaccine Reactions in Children and Teens/Adults

For your convenience, approximate dosages based on weight and age are provided in the charts below. Please confirm that you are administering the correct dose for your patient.

First-Line Treatment: ***Epinephrine*** **(recommended dose for epinephrine is 0.01 mg/kg body weight)**					
Infants & Childr en	**Age Group**	**Weight Range (lb.)**	**Weight Range (kg)***	**Epinephrine Dose**	**Auto-Injector**
				1 mg/ml injectable (1:1000 dilution) Intramuscular Minimum dose: 0.05 ml	Auto-injector (0.10 mg or 0.15 mg or 0.30 mg per dose)
	1 - 6 months	9 - 19 lb.	4 - 8.5 kg	0.05 mL	N/A
	7 - 36 months	20 - 32 lb.	9 - 14.5 kg	0.10 mL	0.10 mg
	37 - 59 months	33 - 39 lb.	15 - 17.5 kg	0.15 mL	0.15 mg
	5 - 7 years	40 - 56 lb.	18 - 25.5 kg	0.20 - 0.25 mL	0.15 mg
	8 -10 years	57 - 76 lb.	26 - 34.5 kg	0.25 - 0.30 mL	0.30 mg
Teens/ Adults	11 - 12 year	77 - 99 lb.	35 - 45 kg	0.35 - 0.40 mL	0.30 mg
	13 years & older	100 + lb.	46 + kg	0.50 mL	0.30 mg

Note: If body weight is known, then dosing by weight is preferred. If weight is not known or not readily available, dosing by age is appropriate.
*Rounded weight at the 50th percentile for each age range.
Maximum dose for children: Dose according to chart, max of 3 injections, 5-15 min apart
Maximum dose for teens/adults: 0.5ml/injection, max of 3 injections, 5-15 min apart

Secondary Treatment Option: <u>Diphenhydramine</u> **(recommended dose for the diphenhydramine (<u>Benadryl</u>) is 1-2 mg/kg body weight)**				
Infants and Children	**Age Group**	**Weight Range (lb.)**	**Weight Range (kg)***	**Diphenhydramine Dose**
				50 mg/mL injectable (IV or IM)
	7 - 36 months	20 - 32 lb.	9 - 14.5 kg	10 mg - 20 mg (0.20 - 0.30 ml)
	37 - 59 months	33 - 39 lb.	15 - 17.5 kg	15 mg - 30 mg (0.30 - 0.40 ml)
	5 - 7 years	40 - 56 lb.	18 - 25.5 kg	20 mg - 30 mg (0.40 - 0.50 ml)
Teens/Adult s	8 - 12 year	57 - 99 lb.	26 - 45 kg	30 mg (0.50 ml)
	13 years & older	100 + lb.	46 + kg	50 mg (1.0 ml)

Note: If body weight is known, then dosing by weight is preferred. If weight is not known or not readily available, dosing by age is appropriate.
*Rounded weight at the 50th percentile for each age range.
Maximum dose: 1-2 mg/kg. ***<u>Do not repeat initial dose.</u>***

LEFT

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INTENTIONALLY

VAERS Vaccine Adverse Event Reporting System
www.vaers.hhs.gov

Adverse events are possible reactions or problems that occur during or after vaccination. Items **2, 3, 4, 5, 6, 17, 18** and **21** are **ESSENTIAL** and should be completed. Patient identity is kept confidential. Instructions are provided on the last two pages.

INFORMATION ABOUT THE PATIENT WHO RECEIVED THE VACCINE (Use **Continuation Page** if needed)

1. Patient name: (first) _____ (last) _____
Street address: _____
City: _____ State: _____ County: _____
ZIP code: _____ Phone: ( ) _____ Email: _____
2. Date of birth: (mm/dd/yyyy) _____ 3. Sex: ☐ Male ☐ Female ☐ Unknown
4. Date and time of vaccination: (mm/dd/yyyy) _____ Time: hh:mm ☐AM ☐PM
5. Date and time adverse event started: (mm/dd/yyyy) _____ Time: hh:mm ☐AM ☐PM
6. Age at vaccination: ___ Years ___ Months 7. Today's date: (mm/dd/yyyy) _____
8. Pregnant at time of vaccination?: ☐ Yes ☐ No ☐ Unknown
If yes, describe the event, any pregnancy complications, and estimated due date if known in item 18!

9. Prescriptions, over-the-counter medications, dietary supplements, or herbal remedies being taken at the time of vaccination:

10. Allergies to medications, food, or other products:

11. Other illnesses at the time of vaccination and up to one month prior:

12. Chronic or long-standing health conditions:

INFORMATION ABOUT THE PERSON COMPLETING THIS FORM

13. Form completed by: (name) _____
Relation to patient: ☐ Healthcare professional/staff ☐ Patient (yourself) ☐ Parent/guardian/caregiver ☐ Other: _____
Street address: _____ ☐ Check if same as item 1
City: _____ State: _____ ZIP code: _____
Phone: ( ) _____ Email: _____
14. Best doctor/healthcare professional to contact about the adverse event: Name: _____ Phone: ( ) _____ Ext: _____

INFORMATION ABOUT THE FACILITY WHERE VACCINE WAS GIVEN

15. Facility/clinic name: _____
Fax: ( ) _____
Street address: ☐ Check if same as item 13
City: _____
State: _____ ZIP code: _____
Phone: ( ) _____

16. Type of facility: (Check one)
☐ Doctor's office, urgent care, or hospital
☐ Pharmacy or store
☐ Workplace clinic
☐ Public health clinic
☐ Nursing home or senior living facility
☐ School or student health clinic
☐ Other: _____
☐ Unknown

WHICH VACCINES WERE GIVEN? WHAT HAPPENED TO THE PATIENT?

17. Enter all vaccines given on the date listed in item 4: (Route is HOW vaccine was given, Body site is WHERE vaccine was given) Use **Continuation Page** if needed

Vaccine (type and brand name)	Manufacturer	Lot number	Route	Body site	Dose number in series
select			select	select	select
select			select	select	select
select			select	select	select
select			select	select	select

18. Describe the adverse event(s), treatment, and outcome(s), if any: (symptoms, signs, time course, etc.)
Use **Continuation Page** if needed

19. Medical tests and laboratory results related to the adverse event(s): (include dates)
Use **Continuation Page** if needed

20. Has the patient recovered from the adverse event(s)?: ☐ Yes ☐ No ☐ Unknown

21. Result or outcome of adverse event(s): (Check all that apply)
☐ Doctor or other healthcare professional office/clinic visit
☐ Emergency room/department or urgent care
☐ Hospitalization: Number of days (if known) _____
Hospital name: _____
City: _____ State: _____
☐ Prolongation of existing hospitalization (vaccine received during existing hospitalization)
☐ Life threatening illness (immediate risk of death from the event)
☐ Disability or permanent damage
☐ Patient died – Date of death: (mm/dd/yyyy) _____
☐ Congenital anomaly or birth defect
☐ None of the above

ADDITIONAL INFORMATION

22. Any other vaccines received within one month prior to the date listed in item 4: Use **Continuation Page** if needed

Vaccine (type and brand name)	Manufacturer	Lot number	Route	Body site	Dose number in series	Date Given
select			select	select	select	
select			select	select	select	

23. Has the patient ever had an adverse event following any previous vaccine?: (If yes, describe adverse event, patient age at vaccination, vaccination dates, vaccine type, and brand name)
☐ Yes _____ ☐ No ☐ Unknown

24. Patient's race: (Check all that apply) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Other: _____

25. Patient's ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

26. Immuniz. proj. report number: (Health Dept use only) _____

COMPLETE ONLY FOR U.S. MILITARY/DEPARTMENT OF DEFENSE (DoD) RELATED REPORTS

27. Status at vaccination: ☐ Active duty ☐ Reserve ☐ National Guard ☐ Beneficiary ☐ Other: _____

28. Vaccinated at Military/DoD site: ☐ Yes ☐ No

FORM FDA VAERS 2.0 (12/20)

SAVE

RETURN TO PAGE 1

COMPLETING THE VACCINE ADVERSE EVENT REPORTING SYSTEM (VAERS) FORM

GENERAL INSTRUCTIONS

- Submit this form electronically using the Internet. For instructions, visit www.vaers.hhs.gov/uploadfile/.
- If you are unable to submit this form electronically, you may fax it to VAERS at 1-877-721-0366.
- If you need additional help submitting a report you may call the VAERS toll-free information line at 1-800-822-7967, or send an email to info@vaers.org.
- Fill out the VAERS form as completely as possible and use the **Continuation Page** if needed. Use a separate VAERS form for each individual patient.
- If you do not know exact numbers, dates, or times, please provide your best guess. You may leave these spaces blank if you are not comfortable guessing.
- You can get specific information on the vaccine and vaccine lot number by contacting the facility or clinic where the vaccine was administered.
- Please report all significant adverse events that occur after vaccination of adults and children, even if you are not sure whether the vaccine caused the adverse event.
- Healthcare professionals should refer to the VAERS Table of Reportable Events at www.vaers.hhs.gov/reportable.html for the list of adverse events that must be reported by law (42 USC 300aa-25).
- Healthcare professionals treating a patient for a suspected vaccine adverse event may need to contact the person who administered the vaccine in order to exchange information and decide how best to complete and submit the VAERS form.

SPECIFIC INSTRUCTIONS

Items 2, 3, 4, 5, 6, 17, 18 and 21 are **ESSENTIAL** and should be completed.

- **Items 4 and 5:** Provide dates and times as specifically as you can and enter as much information as possible (e.g., enter the month and year even if you don't know the day). If you do not know the exact time, but know it was in the morning ("AM") or afternoon or evening ("PM"), please provide that information.
- **Item 6:** If you fill in the form by hand, provide age in years. If a child is less than 1 year old, provide months of age. If a child is more than 1 year old but less than 2 years old, provide year and months (e.g., 1 year and 6 months). If a child is less than 1 month of age when vaccinated (e.g., a birth dose of hepatitis B vaccine) then answer 0 years and 0 months, but be sure to include the patient's date of birth (item 2) and date and time of vaccination (item 4).
- **Item 8:** If the patient who received the vaccine was pregnant at time of vaccination, select "Yes" and describe the event, any pregnancy complications, and estimated due date if known in item 18. Otherwise, select "No" or "Unknown."
- **Item 9:** List any prescriptions, over-the-counter medications, dietary supplements, herbal remedies, or other non-traditional/ alternative medicines being taken by the patient when the vaccine(s) was given.
- **Item 10:** List any allergies the patient has to medications, foods, or other products.
- **Item 11:** List any short-term or acute illnesses the patient had on the date of vaccination AND up to one month prior to this date (e.g., cold, stomach flu, ear infection, etc.). This does **NOT** include the adverse event you are reporting.
- **Item 12:** List any chronic or long-standing health conditions the patient has (e.g., asthma, diabetes, heart disease).
- **Item 13:** List the name of the person who is completing the form. Select the "Check if same as item 1" box if you are the patient or if you live at the same address as the patient. The contact information you provided in item 1 will be automatically entered for you. Otherwise, please provide new contact information.
- **Item 14:** List the doctor or other healthcare professional who is the best person to contact to discuss the clinical details of the adverse event.
- **Item 15:** Select the "Check if same as item 13" box if the person completing the form works at the facility that administered the vaccine(s). The contact information provided in item 13 will be automatically entered for you. Otherwise, provide new contact information.
- **Item 16:** Select the option that best describes the type of facility where the vaccine(s) was given.

- **Item 17:** Include only vaccines given on the date provided in item 4. The vaccine route options include:
  - Injection/shot (intramuscular, subcutaneous, intradermal, jet injection, and unknown)
  - By mouth/oral
  - In nose/intranasal
  - Other (specify)
  - Unknown

  For body site, the options include:
  - Right arm
  - Left arm
  - Arm (side unknown)
  - Right thigh
  - Left thigh
  - Thigh (side unknown)
  - Nose
  - Mouth
  - Other (specify)
  - Unknown

  For vaccines given as a series (i.e., 2 or more doses of the same vaccine given to complete a series), list the dose number for the vaccine in the last column named "Dose number in series."
- **Item 18:** Describe the adverse event(s), treatment, and outcome(s). Include signs and symptoms, when the symptoms occurred, diagnosis, and treatment. Provide specific information if you can (e.g., if patient had a fever, provide the temperature).
- **Item 19:** List any medical tests and laboratory results related to the adverse event(s). Include abnormal findings as well as normal or negative findings.
- **Item 20:** Select "Yes" if the patient's health is the same as it was prior to the vaccination or "No" if the patient has not returned to the same state of health prior to the vaccination, and provide details in item 18. Select "Unknown" if the patient's present condition is not known.
- **Item 21:** Select the result(s) or outcome(s) for the patient. If the patient did not have any of the outcomes listed, select "None of the above." Prolongation of existing hospitalization means the patient received a vaccine during a hospital stay and an adverse event following vaccination occurred that resulted in the patient spending extra time in the hospital. Life threatening illness means you believe this adverse event could have resulted in the death of the patient.
- **Item 22:** List any other vaccines the patient received within one month prior to the vaccination date listed in item 4.
- **Item 23:** Describe the adverse event(s) following any previous vaccine(s). Include patient age at vaccination, dates of vaccination, vaccine type, and brand name.
- **Item 24:** Check all races that apply.
- **Item 25:** Check the single best answer for ethnicity.
- **Item 26:** For health department use only.
- **Items 27 and 28:** Complete only for U.S. Military or Department of Defense related reports. In addition to active duty service members, Reserve and National Guard members, beneficiaries include: retirees, their families, survivors, certain former spouses, and others who are registered in the Defense Enrollment Eligibility Reporting System (DEERS).

GENERAL INFORMATION

- VAERS (www.vaers.hhs.gov) is a national vaccine safety monitoring system that collects information about adverse events (possible reactions or problems) that occur during or after administration of vaccines licensed in the United States.
- VAERS protects patient identity and keeps patient identifying information confidential.
- The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule permits reporting of protected health information to public health authorities including the Centers for Disease Control and Prevention (CDC) and U.S. Food and Drug Administration (FDA) (45 CFR § 164.512(b)).
- VAERS accepts all reports without judging the importance of the adverse event or whether a vaccine caused the adverse event.
- Acceptance of a VAERS report by CDC and FDA does not constitute admission that the vaccine or healthcare personnel caused or contributed to the reported event.
- The National Vaccine Injury Compensation Program (VICP) is administered by the Health Resources and Services Administration (HRSA). The VICP is separate from the VAERS program and reporting an event to VAERS does not constitute filing a claim for compensation to the VICP (see www.hrsa.gov/vaccinecompensation/index.html).
- Knowingly filing a false VAERS report with the intent to mislead the Department of Health and Human Services is a violation of Federal law (18 U.S. Code § 1001) punishable by fine and imprisonment.

O_2 Tank and Emergency Supplies Monthly Log

Year: _____

SUPPLIES & EQUIPMENT	*exam ple*	JUL	AUG	SEP	OCT	NOV	DEC	JAN	F

	12/12/19								
Oxygen Tank - *3/4 full (PSI 1500), key, chain & regulator attached)* ^	*2000*								
Dosage Chart in Emergency Kit +	√								
Epinephrine 1:1000 *	*12/12/21*								
Benadryl *	*12/13/21*								
Bag-Valve Mask (Infant) ^	*1*								
Bag-Valve Mask (Pediatric) ^	*1*								
Bag-Valve Mask (Adult) ^	*1*								
Suction Device (Bulb Syringe) +	√								
Infant O2 Face Mask & Tubing ^	*1*								
Pediatric O2 Face Mask & Tubing ^	*1*								
Adult O2 Face Mask & Tubing ^	*1*								
Nasal Canula (Pediatric) ^	*1*								
Nasal Canula (Adult) ^	*1*								
Nebulizer +	√								
Oral Airways +	√								
Tuberculin syringes with needles *	*11/15/21*								
Alcohol Wipes +	√								
Albuterol SOLN/MDI*	*11/30/21*								
Personal Protective Equipment *(masks, goggles, gowns, gloves)* +	√								
Sterile Dressings +	√								
Splints +	√								
Staff Initials									

PRINT NAME & TITLESIGNATURE INITIALS COMMENTS + checked

* expiration date ^ amount

Document date and appropriate symbol as you check each item.

Initials indicate the supplies have been checked, expired medication and supplies purged, properly disposed of, and the disposal is documented.