Office of the Medical Director
Student Medical Services &
District Nursing Services

ANAPHYLACTIC REACTION
CLINIC EMERGENCY PROTOCOL
(Revised August 19, 2022)

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.

The diagnosis of anaphylaxis is based primarily upon clinical symptoms and signs, as well as a detailed description of the acute episode, including antecedent activities and events occurring within the preceding minutes to hours. Recognition of the variable and atypical presentations of anaphylaxis is critical to providing effective therapy in the form of epinephrine, as well as reducing over-reliance on second-line medications, such as antihistamines and glucocorticoids, that are not lifesaving in anaphylaxis.

Anaphylaxis is highly likely when any ONE of the following three criteria is fulfilled:

1. Acute onset of an illness (minutes to several hours) with involvement of the skin, mucosal tissue, or both (e.g., generalized hives, pruritis or flushing, swollen lips-tongue-uvula) *AND AT LEAST ONE OF THE FOLLOWING:*

    a. Respiratory compromise (e.g., dyspnea, wheeze-bronchospasm, stridor, hypoxemia)
    b. Reduced BP* or associated symptoms of end-organ dysfunction (e.g., hypotonia, collapse, syncope, incontinence)

2. TWO OR MORE OF THE FOLLOWING occur rapidly *after exposure to a LIKELY allergen for that patient* (minutes to several hours):
    a. Involvement of the skin mucosal tissue (e.g., generalized hives, itch-flush, swollen lips-tongue-uvula)
    b. Respiratory compromise (e.g., dyspnea, wheeze-bronchospasm, stridor, hypoxemia)
    c. Reduced BP* or associated symptoms (e.g., hypotonia, collapse, syncope, incontinence)
    d. Persistent gastrointestinal symptoms (e.g., crampy abdominal pain, vomiting)

3. Reduced BP* after exposure to a KNOWN allergen for that patient (minutes to several hours):

    a. Infants and children – Low systolic BP (age-specific)* or greater than 30% decrease in systolic BP
    b. Adults – Systolic BP of less than 90 mmHg or greater than 30% decrease

from that person's baseline blood pressure
*Low systolic blood pressure for children is defined as:
- Less than 70 mmHg from 1 month to 1 year
- Less than (70 mmGH + [2 x age]) from 1-10 years
- Less than 90 mmHg from 11 to 17 years

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.

1. The Senior Physician is responsible for the medical supervision of the immunization program. The names and phone numbers of the School Physicians assigned to each Local District area will be provided by Student Medical Services and should 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 allergies 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. <u>PRECAUTIONS</u>

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) or Epinephrine auto-injectors - 0.10 mg, 0.15 mg and 0.30 mg each per dose
2. Diphenhydramine Hydrochloride (Benadryl) injectable 50 mg/ml
3. Tuberculin (TB) syringe-non retractable
4. 25 gauge 1” safety glide needle
5. Cold packs
6. Sphygmomanometer (infant, child, adult and large adult cuff)
7. Stethoscope
8. Disposable vinyl gloves
9. Cotton balls
10. Alcohol or Alcohol prep pads
11. Sharps container

Per availability: Oxygen and face mask (infant, child, and adult)
***Oxygen supply and equipment must be checked at least once per month and recorded.
Per availability: inhaled bronchodilators, e.g. Albuterol metered-dose inhaler with spacer per dose chart -- see Attachment B; or Albuterol solution with nebulizer, mask, mouthpiece and tubing per Attachment B
(ALBUTEROL SOLUTION NOT TO BE UTILIZED DURING COVID PRECAUTIONS)

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 school physician assigned to the Local District, 2) the school administrator, and 3) parent **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, place in a position of comfort, with lower extremities elevated, if possible, - if vomiting, position patient on their side -If pregnant, position patients on their left side	To maximize perfusion of vital organs & help prevent severe hypotension, subsequent inadequate cardiac filling, and pulseless cardiac activity. To avoid aspiration -To minimize compression of the inferior vena cava by the gravid uterus
4. Prepare appropriate amount**/dose*** of Epinephrine (see Attachment A) 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 c. Draw up required epinephrine dose into syringe or use appropriate dose auto-injector as indicated in Epinephrine Dose (see 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 (see 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.
5. If available, administer supplemental oxygen at 8 to 10 liters by facemask.	

ESSENTIAL STEPS	KEY POINTS AND PRECAUTIONS
6. Place covered cold pack over vaccine injection site.	Have someone else do this if necessary. The cold pack delays absorption of vaccine
7. 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.
8. For the treatment of bronchospasm not responsive to epinephrine, if available: administer albuterol per Attachment B dosing chart. a. Only albuterol via metered-dose inhaler to be utilized during COVID-19 precautions b. Albuterol via nebulizer or compressor via mouthpiece (or facemask for those whose age or condition requires) may be administered only if/when COVID-19 precautions are lifted.	Bronchodilators are adjunctive treatment to epinephrine because they do not prevent or relieve mucosal edema in the upper airway or shock, for which the alpha-1 adrenergic effects of epinephrine are required. The evidence for the use of beta-2 adrenergic agonists in anaphylaxis is extrapolated from their use in acute asthma.
9. Assess for presence of itching and hives. If present, prepare and administer Diphenhydramine (Benadryl) **intramuscularly** per Diphenhydramine Dose Chart (see Attachment A).	Benadryl (50 mg/ml) can be given in addition to epinephrine to relieve itching and hives. Administer once **INTRAMUSCULARLY** (at site other than the epinephrine) according to dosage table. **DO NOT REPEAT**
10. Continue to monitor the patient until the paramedics arrive or as advised by the physician.	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.**
11. 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.
12. Remove gloves if used and wash hands.	

13. Record procedure on permanent health record.	Record the incident in the medical record or a progress note, 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 *(record time, liters and delivery mode of oxygen, if administered). d. Vital signs. Include all blood pressure readings and times e. Patient's response f. District Physician's order/notification. Time and place patient was transported by paramedics and who accompanied (parent, guardian, District personnel, etc.)
14. Report an Adverse Event to VAERS Online	If you need further assistance with reporting to VAERS, please email info@VAERS.org or call 1-800-822-7967.

APPROVED: August 19, 2022

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http://www.immunize.org/catg.d/p3082a.pdf

Attachment A

Medical Management of Vaccine Reactions in Children and Teens

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)**					
	Age Group	**Weight Range (lb.)**	**Weight Range (kg)***	**Epinephrine Dose**	**Auto-Injector**
				1 mg/ml injectable Intramuscular Minimum dose: 0.05 ml Maximum dose: 0.5 ml	Auto-injector (0.10 mg or 0.15 mg or 0.30 mg per dose)
Infants & Children	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	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: 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)**				
	Age Group	**Weight Range (lb.)**	**Weight Range (kg)***	**Diphenhydramine Dose**
				50 mg/mL injectable (IV or IM)
Infants and Children	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	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>***
***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.*

Attachment B

Medical Management of Vaccine Reactions in Children and Teens

For bronchospasm unrelieved by intramuscular epinephrine, give:

Albuterol metered-dose inhaler: 90 mcg/actuation with spacer (add mask in children less than 4 years)

For ages 12 and under:
One-fourth to one-third puff/kg (minimum 4 puffs and maximum 8 puffs) every 20 to 30 minutes up to 3 doses
Dose may also be determined based upon body weight as follows:

- 5 to 10 kg (**11 - 22 pounds**) - **4 puffs**
- 10 to 20 kg (**22 - 44 pounds**) - **6 puffs**
- >20 kg **(>44 pounds**) - **8 puffs** **** 4-8 PUFFS ****

For ages 13 and over:
4 to 8 puffs every 20 minutes as needed

<u>Alternatively, if/when COVID precautions are lifted</u>:

Albuterol solution via nebulizer:
The standard dose for nebulized albuterol is 0.15 mg/kg (minimum 2.5 mg; maximum 5 mg)**:**

- **Children <12 years (a child is defined as a prepubertal patient weighing less than 40 kg/88 pounds):**
  Albuterol 0.15mg/kg (minimum dose: 2.5 mg) in 3 mL saline inhaled via nebulizer.
  Nebulized albuterol can be administered every 20 to 30 minutes for three doses.

- **Children <u>≥</u>12 years (children weighing 40 kg/88 pounds) and Adolescents:**
  Albuterol 2.5 to 5 mg in 3 mL saline inhaled via nebulizer.
  Nebulized albuterol can be administered every 20 to 30 minutes for three doses.

***** MAY USE ALBUTEROL SULFATE SOLN 0.083% PREMIXED VIALS FOR INHALATION PER NEBULIZER 2.5MG PER 3ML****

SOURCE:

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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 (02/22)

SAVE

VAERS

CONTINUATION PAGE (Use only if you need more space from the front page)

17. Enter all vaccines given on the date listed in item 4 (continued):					Dose number in series
Vaccine (type and brand name)	Manufacturer	Lot number	Route	Body site	
select			select	select	select
select			select	select	select
select			select	select	select
select			select	select	select

22. Any other vaccines received within one month prior to the date listed in item 4 (continued):					Dose number in series	Date Given
Vaccine (type and brand name)	Manufacturer	Lot number	Route	Body site		
select			select	select	select	
select			select	select	select	
select			select	select	select	
select			select	select	select	
select			select	select	select	
select			select	select	select	

Use the space below to provide any additional information (indicate item number):

FORM FDA VAERS 2.0 (02/22)

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.

RETURN TO PAGE 1

- **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.

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Medical Services

O_2 Tank and Emergency Supplies Monthly Log

Year: _____

SUPPLIES & EQUIPMENT	*example 12/12/20*	JUL	AUG	SEP	OCT	NOV	DEC
Oxygen Tank - *3/4 full (PSI 1500), key, chain & regulator attached)* ^	*2000*						
Dosage Chart in Emergency Kit +	√						
Epinephrine 1mg/ml *	*12/12/21*						
Diphenhydramine 50mg/ml *	*12/13/21*						
Epinephrine Auto-Injector 0.3mg/ml *	*12/13/21*						
Epinephrine Auto-Injector 0.15mg/ml *	*12/14/21*						
Epinephrine Auto-Injector 0.1mg/ml *	*12/14/21*						
Albuterol MDI 90mcg/inh *	*12/15/21*						
Albuterol SOL 2.5mg/3mL*	*11/12/23*						
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 +	*√*						
Personal Protective Equipment *(masks, goggles, gowns, gloves)* +	*√*						
Sterile Dressings +	*√*						
Splints +	*√*						
Staff Initials	***AA***						

STAFF NAME, TITLE & INITIALS

_____

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_____

Document date and appropriate symbol as you check each item
+checked
***expiration date**
^amount

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

NOTES:

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LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Medical Services

O_2 Tank and Emergency Supplies Monthly Log

Year: _____

SUPPLIES & EQUIPMENT	*example 12/12/20*	JAN	FEB	MAR	APR	MAY	JUN
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Epinephrine Auto-Injector 0.1mg/ml *	*12/16/21*						
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Albuterol SOL 2.5mg/3mL*	*11/12/23*						
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Nasal Canula (Adult) ^	*1*						
Nebulizer +	*√*						
Oral Airways +	*√*						
Tuberculin syringes with needles *	*11/15/21*						
Alcohol Wipes +	*√*						
Personal Protective Equipment *(masks, goggles, gowns, gloves)* +	*√*						
Sterile Dressings +	*√*						
Splints +	*√*						
Staff Initials	***AA***						

STAFF NAME, TITLE & INITIALS

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