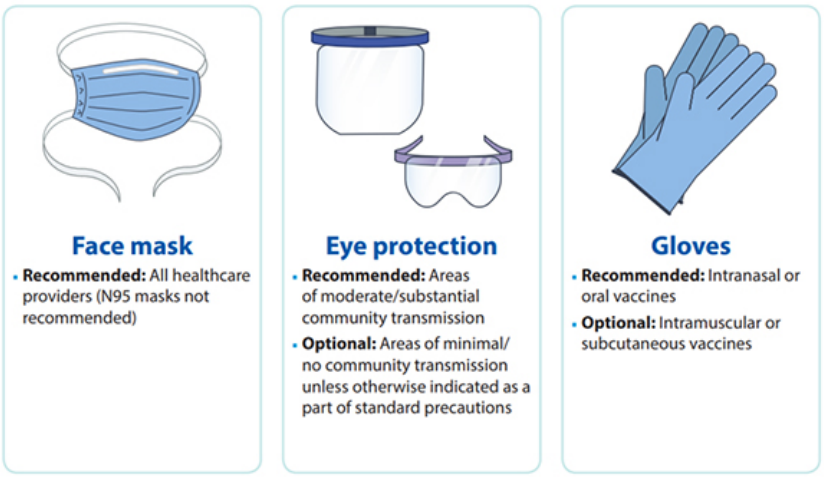
CHECKLIST for Nurses and EMS Personnel
Administering Afluria Quadrivalent Vaccine
GMVEMSC JITSO for Paramedics and Adv. EMTs
09/5/2024

Afluria Quadrivalent Vaccine is an inactivated influenza vaccine for active immunization against influenza disease. This is caused by influenza A subtype viruses and type B viruses.

- **9** years of age and older, administered as one primary dose (0.5 mL).



Storage and Dose Preparation

Afluria Quadrivalent is stored within a pre-filled syringe. Each individual package contains 10 (0.5mL) single-dose syringes with Luer-Lok attachment without needles.

- The samples should be stored between 2-8 degrees Celsius, which is 36-46 degrees Fahrenheit.
- The package should not be frozen; if frozen should be discarded.
- Protect from light.
- Do not use past the expiration date on the label.

Indications

One dose (0.5 mL) of Afluria Quadrivalent Vaccine is limited to the following (all requirements **must** be met):

- This Just in Time Standing Order (JITSO) is for use in individuals **18** years of age and older.
- Provide "Vaccine Information Sheet" to patient and review their completed "Vaccine Screening and Consent" **prior** to giving the Vaccine.
- The full effect of the vaccine should be observed within three weeks after vaccination.
- Vaccine protection wanes over time; optimal time for vaccination may be in October.

Contraindications

Do not administer the Afluria Quadrivalent Vaccine to any individual with a known severe allergic reaction. One such reaction is known as Anaphylaxis. Do not administer the Afluria Quadrivalent Vaccine to any individual who has had a severe allergic reaction to egg products, eggs, or any influenza vaccine. Refer patient to their primary care provider for consideration of the benefits and risks of vaccination.

Warnings and Precautions

- Appropriate treatment to manage immediate allergic or anaphylactic reactions must be immediately available.
- If Guillain-Barré Syndrome has occurred within 6 weeks of previous influenza vaccine, the patient should be referred to their primary healthcare provider for consideration of the benefits and risks of vaccination.
- If administered to immunocompromised persons, including those receiving immunosuppression therapy, the immune response may be diminished.
- The vaccination may not protect all individuals.

Adverse Reactions

- The most commonly reported injection-site adverse reaction was pain.
- The most common systemic adverse effects were myalgia, headache, and fatigue or malaise.

Vaccine Administration

Administered intramuscularly (IM) as a series of one dose (0.5 mL).

- Shake the vaccine thoroughly before use and inspect visually.
- The drug product should be examined for discoloration and foreign particulate matter prior to administration. If either condition exists, then the vaccine should not be administered.
- When using the single dose pre-filled syringe, shake properly, and administer immediately.
- If using the multi-dose vial, the dosage should be drawn using a separate sterile needle and syringe for each individual patient. It is recommended to use syringes that only hold 0.5 mL or 1 mL.

IM Injections in Deltoid Muscle

- **Use proper landmarks and technique to identify the injection site.**
- **Use proper needle length for age and size of patient.**
- **Aspiration is not recommended when administering vaccines.**

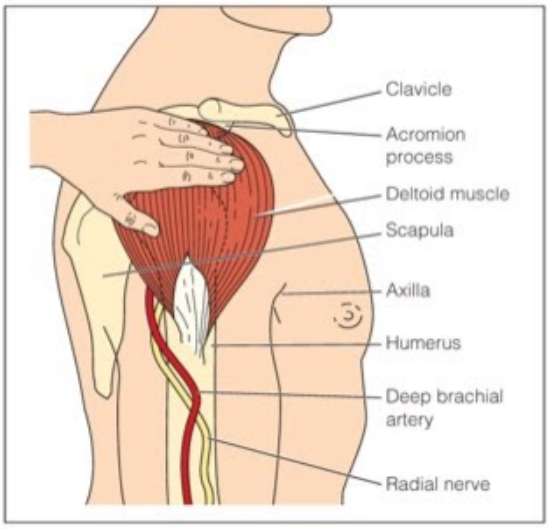
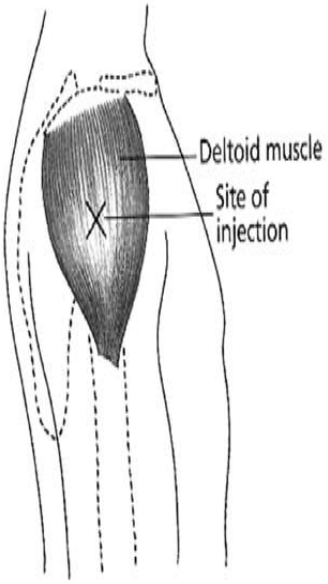


FIGURE 31.38 A method of establishing the deltoid muscle site for an intramuscular injection



Monitoring and Reporting Requirements

- You MUST provide the "Vaccine Information Sheet" (VIS) to each patient and review their completed "Vaccine Screening and Consent" **prior** to giving the Vaccine.
    - VIS (**download and print**): https://www.immunize.org/wp-content/uploads/vis/flu_inactive.pdf
- Document the following information (**prefilled items in bold**):
    - Agency:
    - Vaccination Location (e.g., Station Number or other location)
    - Patient Name:
    - Birth Date:
    - Sex:
    - Race:
    - Ethnicity:
    - Address, City, State, & Zip:
    - Phone Number:
    - Date of Vaccination:
    - Vaccine Manufacturer/Brand: **Seqirus Afluria Quadrivalent**
    - Lot Number:
    - Anatomical Route: **IM**
    - Anatomical Site: **Deltoid**
    - Vaccination Dose: **0.5 mL**
    - Keep a copy of each patient's "Vaccine Screening and Consent" (attached as last page).
- **The vaccination provider is responsible for mandatory reporting of the following to the Vaccine Adverse Event Reporting System (VAERS).**
    - Vaccine administration errors whether or not associated with an adverse event, serious adverse events* (irrespective of attribution to vaccination).
    - Submit reports to VAERS online at https://vaers.hhs.gov/reportevent.html.
- Vaccinations by EMS require a written protocol approved by the agency medical director and any necessary training.
- Any vaccines being used must be included on agency's drug list. When updating the list with the Ohio Board of Pharmacy (OBP), the licensee must then upload the entire drug list (not just updates) signed by the agency's medical director, which will replace the current drug list on file so the list being uploaded must include all drugs (not just updates) that may be purchased and possessed by the licensee. It is not necessary to send the protocol to OBP.
- Not later than thirty days after the immunization is administered, notify the local board of health where the individual receiving the immunization resides or the Ohio Department of Health.

Dosing Time Frames

Primary series

Afluria Quadrivalent vaccine is administered intramuscularly as a single dose annually

Vaccine manufacturer	Primary dose	Primary dose volume	Number doses/series	Interval between primary doses	Interval between primary and booster doses
Seqirus	0.5 mL	0.5 mL	1	None	One year

2024-2025
Inactivated Injectable Influenza Vaccine Administration Form

Client Information

PLEASE WRITE LEGIBLY.

Last Name	First Name	M.I.	*Date of Birth*	*Age*	*Sex* ☐ *Male* ☐ *Female*

Address	City/Township	State	*Zip*	*County*

Phone:	Parent/Guardian Name (only if client is under age 18)	*Race (for statistical use only)* ☐ *Asian Pacific* ☐ *White* ☐ *Other* ☐ *Black* *Native American*	*Hispanic?* ☐ *Yes*
May we leave a message? ☐ Yes ☐ No			

Answer a few short questions so we can make sure that the vaccine can be given today

Y☐	☐ No	☐ Don't Know	Is the person to be vaccinated sick today?
Y☐	N☐	☐ Don't Know	Does the person to be vaccinated have an allergy to a component of the vaccine? If Yes, List allergies:
Y☐	N☐	☐ Don't Know	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?
Y☐	N☐	☐ Don't Know	Has the person to be vaccinated ever had Guillain-Barre' Syndrome?

Email Address	Emergency Contact: First Name, Last Name, Phone#	*Language* ☐ *English* ☐ *Other:*_____	

Client Consent (or Parent/Guardian Consent for clients age 17 & under) - read and sign/date below.

I was given an explanation about the diseases and vaccines. I had the opportunity to ask questions that were answered to my satisfaction and/or received a Vaccine Information Sheet. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. I hereby consent that the Local Health Department (LHD), or designee, from whom I received the vaccination can bill my insurance, if applicable. I understand I am financially responsible for any fees not covered by my insurance company. I authorize the release of this record to the Ohio Department of Health Immunization Program. I hereby acknowledge receipt of the LHD Notice of Health Information Privacy Practice and give permission to release my immunization record to my doctor or agency/school. If indicated on this form, I authorize the LHD or designee to charge my account. For clients age 17 and under, parent and/or guardian consents to allow client to receive vaccine without parent and/or guardian present.

SIGN Name: X _____ Date: _____

Payment Information (complete insurance OR self-pay area below)

INSURANCE – (complete insurance info below **AND** in box to the left write 1 or 2 to indicate primary/secondary)	SELF-PAY
Medicare (Traditional Part B) ID# _____	☐ Cash
Medicare HMO (ie, Anthem Medicare Advantage, Secure Horizons Medicare Advantage) Name of Plan: _____ ID# _____	☐ Check # _____
Medicaid (ie, Traditional Medicaid, CareSource, Molina, Paramount, UHC Community) Name of Plan: _____ ID# _____	☐ Credit Card Type _____ Acct# _____ Exp. Date _____
Private Insurance Company Name: _____ Member ID: _____ Group: _____ Plan:_____ Policy Holder Name & Date of Birth: _____ ___/___/_____ Relationship to Policy Holder: _____	Amount: _____ Receipt # _____ Received By: _____
Other (ie, company voucher, etc) ID# _____	

---------- Office Use Only ----------

Vaccine Administered Information

SC = subcutaneous IM = intramuscular ID = intradermal IN = intranasal

Vaccinating Agency: _____

Date	Vaccine Name	Vaccine Lot #	Mfg	RA	LA	RT	LT	Nose	Dose (check box) 0.5 ml	Dose 0.2ml LAIV			Vaccinator Initials
	Fluzone	**U8200DA**	**Sanofi**	**IM**	**IM**				**x**				

Clinic site: **VIS:** ☒ **08/06/2021** **Vaccinator signature**

Flnacated Injectable Influenza Vaccination Form 09/06/2024