DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

30 March 2007

MEMORANDUM FOR SEE DISTRIBUTION

FROM: HQ USAF/SG3
110 Luke Avenue, Room 400
Washington DC 20032-7050

SUBJECT: Smallpox Immunization Program Safety – Remain Vigilant

The resumption of mandatory anthrax vaccinations and a recent, life-threatening case of eczema vaccinatum highlight the need to focus our attention on policies and procedures of smallpox vaccination. MTF commanders must ensure their medics are trained, understand the requirements of the Smallpox Vaccination Implementation Plan, and are using all the most updated tools provided (see attached). Providers and immunization staff must be aware of and utilize exemptions and deferrals as appropriate. The attached guidelines provide detailed guidance on these issues.

My POC for this issue is Col Michael Snedecor, AFMOA/SG3PM, (202) 767-4268, DSN 297-4268, or: michael.snedecor@pentagon.af.mil.

THOMAS J. LOFTUS
Major General, USAF, MC, CFS
Assistant Surgeon General, Health Care Operations
Office of the Surgeon General

Attachments:
1. Smallpox Vaccination Implementation Plan
2. Smallpox Clinical Note Forms
3. Smallpox Vaccination Program Guidance

DISTRIUBTION:
See Attached List

SG3 DOC: 07-029

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See Air Force Smallpox Vaccination Implementation Plan
http://www.vaccines.mil/documents/171airforcePlan.pdf

CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 1 (2-Page Format)

45657

Shade Circles Like This--> ●
Not Like This--> ⊗ ✓

This page may be completed by potential vaccine recipient

1. Today's Date (M M / D D / Y Y Y Y) ☐☐ / ☐☐ / ☐☐☐☐

2a. GENDER ○ Male ○ Female 2b. First day of last normal menstrual period: ___ / ___ / _____

2c. FEMALES: Was your last menstrual period normal and on time? ○ Yes ○ No ○ Unsure

2d. Are you currently breastfeeding? ○ Yes ○ No

3. Could someone you LIVE WITH or YOU be pregnant? ○ Yes ○ No ○ Unsure

4. Do you have a child in the home less than one year of age? ○ Yes ○ No ○ Unsure

5. Did you ever receive smallpox vaccine? ○ Yes ○ No ○ Unsure

5a. IF YES: Were you vaccinated within the last 10 years? ○ Yes ○ No ○ Unsure

5b. IF UNSURE: Birth Year ☐☐☐☐ First Year in Military (if applicable) ☐☐☐☐

6. Have you ever had a serious problem after smallpox or other vaccination? (Describe below) ○ Yes ○ No ○ Unsure

7. Do you currently have an illness with fever? ○ Yes ○ No ○ Unsure

8. Do you have a heart or vessel condition, such as angina, earlier heart attack, coronary artery disease, congestive heart failure, cardiomyopathy, stroke, "mini stroke," chest pain or trouble breathing on exertion? ○ Yes ○ No ○ Unsure

9. Check EACH of the following conditions that apply to you:
☐ Heart Condition before age 50 in mother, father, brother, sister
☐ Smoke cigarettes now ☐ High blood pressure ☐ High cholesterol ☐ Diabetes or high blood sugar

10. Are you allergic to any of these products: tetracycline, streptomycin, polymyxin B, neomycin, latex? ○ Yes ○ No ○ Unsure

11. Do you NOW HAVE or have you EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.) ○ Yes ○ No ○ Unsure

12. Do you NOW HAVE any of the following skin problems: Psoriasis (scaly skin rash), Burns (other than mild sunburn), Impetigo (skin infection), Uncontrolled Acne, Shingles (herpes zoster), Chickenpox, Darier's disease, Other Skin Condition (Describe below)? ○ Yes ○ No ○ Unsure

13. Do you have a problem or take a medication that affects the immune system? For example, do you ○ Yes ○ No ○ Unsure
have or take medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem;
have or take medication for Crohn's disease, lupus, arthritis, or other immune disease;
have had radiation or X-ray treatment (not routine X-rays) within the last 3 months;
have EVER had a bone-marrow or organ transplant (or take medication for that); or
have another problem that requires steroids, prednisone or a cancer drug for treatment.

14. Are you currently being treated with steroid eye drops or ointment, or have you had recent eye surgery? ○ Yes ○ No ○ Unsure

15. Do you LIVE WITH anyone who NOW HAS or EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.) ○ Yes ○ No ○ Unsure

16. Do you LIVE WITH anyone who NOW HAS any of the following skin problems: Psoriasis (scaly skin rash), Burns (other than mild sunburn), Impetigo (skin infection), Uncontrolled Acne, Shingles (herpes zoster), Chickenpox, Darier's disease, Other Skin Condition (Describe below)? ○ Yes ○ No ○ Unsure

17. Do you LIVE WITH someone who has a problem or takes a medication that affects the immune system? ○ Yes ○ No ○ Unsure
For example do you have a close household contact who
has or takes medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem;
has or takes medication for Crohn's disease, lupus, arthritis, or other immune disease;
has had radiation or X-ray treatment (not routine X-rays) within the last 3 months;
has EVER had a bone-marrow or organ transplant (or take medication for that); or
has another problem that requires steroids, prednisone or a cancer drug for treatment.

18. Do you have other questions or have other concerns you would like to discuss? ○ Yes ○ No

NOTE: If you think you might have one of the many risk factors for HIV infection, we can arrange for HIV testing before vaccination.
FOR FEMALES: If you might be pregnant, or likely to become pregnant, please tell us. You may need additional pregnancy testing.

Explain "other," "unsure" or additional concerns (may use additional page)

Last Name

First Name MI

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Patient's Identification (May use for mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
DEPT/SVC

45657

CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 2 (2-Page Format)

This page to be completed by a health care provider

1. Provider Assessment Date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

If Provider Assessment Date or Action Taken Immunization Date is blank, Default is "Today's date" on page 1.

2. Reason for Vaccination (Indicate One):

- ○ Pre-outbreak: disease prevention
- ○ Post-outbreak: not exposed to virus
- ○ Post-outbreak: exposed to virus
- ○ Other reason (Describe)

3. Vaccine Risk Factors based on page 1 review and interview (Check all that apply):

	Self	Close Contact
No restriction	○	○
Pregnancy	○	○
Immune supression	○	○
Skin condition	○	○
Relevant allergy	○	
Heart condition	○	
Unsure	○	

3+ RF ○

○ (Describe)

4. Provider comment on any concerns about contraindications, need to defer, need to consult, and/or relevent diagnosis

5. Provider Decision and Plan (Check all that apply):

- ☐ Vaccinate: Primary (e.g. birth year>1972, military entry >1984)
- ☐ Vaccinate: Revaccination
- ☐ Medically immune: vaccinated within approp interval (MI)
- ☐ Vaccination deferred: Pending consult or lab test
- ☐ Vaccination deferred: Temporary contraindication (MT)
- ☐ Vaccination contraindicated unless exposed (MP)
- ☐ Vaccination not given (other reason specify below):

6. IF NOT IMMUNIZED, Check all that apply:

- ☐ Reason for non-immunization explained
- ☐ Lab test requested
- ☐ Consult request written/sent
- ☐ Follow up appointment planned
- ☐ Other reason (specify below):

List labs or consults requested, and length of temp referrals

Provider Signature and Printed Name/Stamp:

VACCINE ADMINISTRATION:

7. Vaccination Action Taken: Vaccination Date (M M / D D / Y Y Y Y) ☐☐ / ☐☐ / ☐☐☐☐

Location: ○ Left Arm ○ Right Arm ○ Other location (describe)

Number of Jabs: ☐☐

Lot # ☐☐☐☐☐☐☐ Mfr ☐☐☐

For QA use: local vial serial # ☐☐☐

8. IF IMMUNIZED, Check all that apply:

- ☐ Information sheet given to recipient
- ☐ Recipient advised about post-vaccination reaction and care
- ☐ Reasons for follow-up clinic visit described
- ☐ Patient understands information given
- ☐ Bandages provided if needed

Please assure that all actions taken and deferrals are updated into your service's electronic Immunization Tracking System (ITS) as soon as possible.

Vaccine administered by: (Signature and Printed Name/Stamp)

Last Name

First Name MI

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Patient's Identification (May use for mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
DEPT/SVC

9965

CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 3 (3-Page Format)

This page may be completed by health care provider or vaccine administrator

VACCINE ADMINISTRATION

Immunization Date (M M / D D / Y Y Y Y)

Date Briefed (M M / D D / Y Y Y Y)

Vaccination Adminstration Site Name

Vital Signs (if indicated) Temp . Resp Pulse BP /

Immunized; number of jabs:

Location: ○ Left Arm ○ Right Arm ○ Other Location (Describe)

Lot # Mfr

For QA use: local vial serial #

Check all that apply:

- ☐ Information sheet given to recipient
- ☐ Recipient understands information given about post-vaccination reaction and site care
- ☐ Vaccination site observation: no break in skin
- ☐ Vaccination site observation: trace blood
- ☐ Vaccination site observation: petechia(e)
- ☐ Vaccination site observation: frank bleeding
- ☐ Bandages provided
- ☐ Reasons for follow-up clinic visit described
- ☐ Vaccination repeated

Additional Comments (e.g., reason for vaccination repeat)

Vaccine administered by: (Signature and Printed Name/Stamp)

Please assure that all actions taken and deferrals are updated into your service's electronic Immunization Tracking System (ITS) as soon as possible.

Last Name

First Name MI

Social Security Number - -

Patient's Identification (May use mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
DEPT/SVC

CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 1 (3-Page Format)

9965

This page may be completed by potential vaccine recipient

Shade Circles Like This--> ●
Not Like This--> ⊗ ✓

1. Today's Date (M M / D D / Y Y Y Y) ☐☐/☐☐/☐☐☐☐

2a. GENDER ○ Male ○ Female 2b. First day of last normal menstrual period:

2c. FEMALES: Was your last menstrual period normal and on time? ○ Yes ○ No ○ Unsure

2d. Are you currently breastfeeding? ○ Yes ○ No

3. Could someone you LIVE WITH or YOU be pregnant? ○ Yes ○ No ○ Unsure

4. Did you ever receive smallpox vaccine? ○ Yes ○ No ○ Unsure

4a. IF YES: Were you vaccinated within the last 10 years? ○ Yes ○ No ○ Unsure

4b. IF UNSURE: Birth Year ☐☐☐☐ First Year in Military (if applicable) ☐☐☐☐

5. Have you ever had a serious problem after smallpox or other vaccination? (Describe below) ○ Yes ○ No ○ Unsure

6. Do you currently have an illness with fever? ○ Yes ○ No ○ Unsure

7. Are you allergic to any of these products: tetracycline, streptomycin, polymyxin B, neomycin, latex? ○ Yes ○ No ○ Unsure

Before vaccinating against smallpox, we want to know if you or your household close contacts have any of several medical conditions. Please answer the following questions to the best of your knowledge.

	Myself		Close Contact	
8. Do you OR someone you currently live with NOW HAVE any of the following skin problems: Psoriasis (scaly skin rash), Burns (other than mild sunburn), Impetigo (skin infection), Uncontrolled Acne, Shingles (herpes zoster), Chickenpox, Darier's disease or Other skin condition with multiple breaks in skin (describe below)?	○ Yes ○ No ○ Unsure		○ Yes ○ No ○ Unsure	
9. Do you OR someone you currently live with NOW HAVE or RECENTLY HAD a problem or take(s) medication that affects the immune system? For example: have or take medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem; have or take medication for Crohn's disease, lupus, arthritis, or other immune disease; have had radiation or X-ray treatment (not routine X-rays) within the last 3 months; have EVER had a bone-marrow or organ transplant (or take medication for that); or have another problem that requires steroids, prednisone or a cancer drug for treatment.	○ Yes ○ No ○ Unsure		○ Yes ○ No ○ Unsure	
10. Have you OR someone you currently live with EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.) IF YES or UNSURE: for either you or your close contact, Answer 10a-10e	○ Yes ○ No ○ Unsure		○ Yes ○ No ○ Unsure	
10a. A doctor has made the diagnosis of eczema or atopic dermatitis.	○ Yes ○ No ○ Unsure		○ Yes ○ No ○ Unsure	
10b. There have been itchy rashes that have lasted more than 2 weeks.	○ Yes ○ No ○ Unsure		○ Yes ○ No ○ Unsure	
10c. At least once, there is a history of an itchy rash in the folds of the arms or legs.	○ Yes ○ No ○ Unsure		○ Yes ○ No ○ Unsure	
10d. There is a history of eczema and food allergy during childhood.	○ Yes ○ No ○ Unsure		○ Yes ○ No ○ Unsure	
10e. A doctor has made the diagnosis of asthma or hayfever (including first-degree relatives).	○ Yes ○ No ○ Unsure		○ Yes ○ No ○ Unsure	

11. Are you being treated with steroid eye drops or ointment or have you had recent eye surgery? ○ Yes ○ No ○ Unsure

12. Do you have a heart or vessel condition, such as angina, earlier heart attack, artery disease, congestive heart failure, cardiomyopathy, stroke, "mini stroke," chest pain or trouble breathing on exertion? ○ Yes ○ No ○ Unsure

13. Check EACH of the following conditions that apply to you:
☐ Heart Condition before age 50 in mother, father, brother, sister
☐ Smoke cigarettes now ☐ High blood pressure ☐ High cholesterol ☐ Diabetes or high blood sugar

14. Do you have a child in home less one year of age? ○ Yes ○ No

15. Do you have other questions or have other concerns you would like to discuss? ○ Yes ○ No

Explain "other," "unsure," or additional concerns (may use additional page). NOTE: If you might have a risk factor for HIV infection, we can arrange for HIV testing. FOR FEMALES: If you might be pregnant, or likely to become pregnant, please tell us. You may need additional pregnancy testing.

Last Name

First Name MI

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Patient's Identification (May use mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
DEPT/SVC

CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 2 (3-Page Format)

9965

This page to be completed by health care provider

Vaccinee number (optional for QA)

1. Provider Assessment Date (MM/DD/YYYY)

__/__/____

2. Reason for Vaccination (Indicate One):

- ○ Pre-outbreak: disease prevention
- ○ Post-outbreak: not exposed to virus
- ○ Post-outbreak: exposed to virus
- ○ Other reason (Describe)

3. Vaccine Risk Factors based on page 1 review and interview (Check all that apply):

	Self	Close Contact
No restriction	○	○
Pregnancy	○	○
Immune supression	○	○
Skin condition	○	○
Relevant allergy	○	
Heart condition	○	3+ RF ○
Unsure	○	○

(Describe)

4. Comment on any concerns about contraindications, need to defer, need to consult, and/or relevent diagnosis

5. Provider Decision and Plan (Check all that apply):

- ☐ Vaccinate: Primary (e.g. birth year >1972, military entry >1984)
- ☐ Vaccinate: Revaccination
- ☐ Medically immune: vaccinated within approp interval (MI)
- ☐ Vaccination deferred: Pending consult or lab test
- ☐ Vaccination deferred: Temporary contraindication (MT)
- ☐ Vaccination contraindicated unless exposed (MP)
- ☐ Vaccination not given (other reason specify below):

6. Provider Action, Check all that apply:

- ☐ Reason for vaccination decision explained
- ☐ Patient understands information given
- ☐ Lab test requested
- ☐ Consult request written/sent_____
- ☐ Follow up appointment planned (Date: _____)
- ☐ Other reason (specify below):

Provider Plan and Action Additional Comments (e.g., length of temporary deferrals, what labs/consults requested)

Provider Signature and Printed Name/Stamp:

Last Name

First Name MI

Social Security Number ___ - ___ - ____

Patient's Identification (May use mechanical imprint)

RECORDS MAINTAINED AT:
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Updated Smallpox Vaccine Program Guidance—March 2007

AF Smallpox vaccine policy is defined in the Air Force Smallpox Vaccination Implementation Plan dated January 2003 and messages listed at the A3 C-CBRNE website: https://www.a3a5.hq.af.mil/a3s/a3sc/CCBRN_resource/biological/smallpox/index.asp

DoD currently requires smallpox vaccination for designated high threat areas (CENTCOM, Korea), as well as some defined priority groups (e.g. smallpox vaccinator cadres, smallpox medical teams, and the smallpox epidemiologic response team at AFIOH.). MTFs are still required to have identified and vaccinated smallpox vaccinator cadres.

Clinical Guidance References

Follow guidance in the vaccine package insert (particularly for information on contraindications to vaccination) and from the Centers for Disease Control and Prevention (CDC), which formally publishes recommendations from the Advisory Committee for Immunization Practice (ACIP), for the administration of vaccines unless superseded by AF or DoD policy.

DoD clinical policy is defined in ASD(HA) memo, "Clinical Policy for the DoD Smallpox Vaccination Program (SVP)", dated 26 Nov 2002. (Do not use the screening questionnaire attached to that memo- see below.)

AF clinical policy, which incorporates DoD guidance, is found in Annex D of the SVP Implementation Plan and as follows.

Updates on Specific Clinical Issues

Pre-vaccination Screening

All potential vaccinees must be screened for contraindications before receiving the smallpox vaccine. Current "Smallpox Vaccination Initial Note" must be used. Potential vaccine recipients complete page 1. These forms are available on the MILVAX forms website in the smallpox section: http://www.vaccines.mil/default.aspx?cnt=resource/formsAll

Any "Yes" answers to screening questions for the individual or his/her household contacts require evaluation by a privileged provider to determine disposition. Any "Unsure" answers or individual concerns listed also require evaluation by a privileged provider. Providers must complete appropriate sections of pg. 2 on the smallpox initial note form, and document their decision for or against vaccination. If the provider determines that the smallpox vaccine can be administered, the vaccinator must fill out the appropriate sections of pg 2. or pg. 3 if the 3 page format is used.

AF policy is to defer all vaccinations for individuals with contraindications for vaccinations, and for those who have household contacts with contraindications to vaccination. Vaccinations should be deferred for individuals with household contacts < 12 months of age. (In an emergency situation there is no absolute contraindication to vaccination, and the risk of vaccination must be evaluated against the risk of a potential smallpox infection.)

Refer to the package insert for a comprehensive list of contraindications to vaccination. Available at the MILVAX package insert site:
http://www.vaccines.mil/default.aspx?cnt=resource/quickReferenceCategories&sID=16

Clinical Consultation Resources

If providers have questions about contraindications, the need for an exemption, adverse events after vaccination or possible contact transfer, they can contact the DoD Vaccine Healthcare Centers at 202-782-0411, www.vhcinfo.org. They can also contact the DoD Vaccine Clinical Call center 24 hours a day, 7 days a week. That number is 1-866-210-6469.

Documentation of Contraindications/Exemptions

All contraindications and any exemptions must be documented appropriately in the medical record. If required, exemptions must be documented appropriately on the smallpox initial note, as well as in AFCITA (and on the DD2766C if required for deployment). Documentation in AHLTA and/or the hard copy medical record should follow established business rules. At a minimum the completed smallpox vaccination initial note must be included in the medical record.

If a temporary medical exemption is required, the release date must be entered in AFCITA and documented on the DD2766C if appropriate. (CENTAF requires that exemptions are also documented on the individual deployer's CENTAF Outprocessing checklist in sect.6. The expiration date for temporary exemptions should be within 7 days of the AOR Required Delivery Date (RDD).)

Education for Vaccine Recipient and Household Contacts

It is imperative that vaccinees are thoroughly educated on inoculation site care and precautions necessary to protect themselves and others from contact transmission of vaccinia, with emphasis on protection of close household contacts. It is essential that medical personnel ensure Service members understand the contraindications, precautions post-vaccination, and contact prohibition guidelines at the time of the inoculation.

At a minimum, vaccine recipients must be educated and receive the most current version of the Smallpox Vaccine Trifold brochure. Patients must be given time to review the brochure and have all questions answered before receiving smallpox vaccine. Women should be advised to avoid becoming pregnant for four weeks after vaccination.

Household contacts of vaccine recipients must have appropriate information necessary to protect themselves against contact transfer.

The trifold brochure providing education for vaccinees, the trifold for household contacts of a vaccine-recipient, and information on protecting animals against vaccinia transfer can be found at the following website:
http://www.vaccines.mil/default.aspx?cnt=resource/brochuresDisease&dID=22

DoD beneficiaries and their family members with questions about a vaccination can call the DoD Vaccine Clinical Call center 24 hours a day, 7 days a week at 1-866-210-6469. Information on this call center is found on the smallpox trifold brochures.

Reporting Adverse Reactions

All significant post-vaccination adverse events must be reported to the DoD Vaccine Healthcare Center network. Reporting must be timely, as VHCs will coordinate care with local providers at civilian facilities or military, when necessary. They will also coordinate with the CDC and assist in procuring a supply of VIG if needed.

Contact information for the VHC network can be found at this website: http://www.vhcinfo.org/vhcnet_contact.htm If reporting is required after normal VHC hours, please contact the DoD Vaccine Clinical Call Center at 1-866-210-6469. The call center is available 24 hours a day, 7 days a week.

All adverse events after smallpox vaccination must also be reported through the Vaccine Adverse Event Reporting System, IAW guidance in AFJI 48-110, *Immunizations and Chemoprophylaxis*, sect. 2-10.

The following list of adverse reactions must be reported to VAERS and VHC at a minimum:

Superinfection of the vaccination site or regional lymph nodes
Inadvertent autoinoculation (nonocular)
Contact transmission (nonocular)
Ocular vaccinia
Generalized vaccinia
Eczema vaccinatum
Progressive vaccinia
Erythema multiforme major or Stevens-Johnson Syndrome
Fetal vaccinia
Postvaccinial central nervous system disease
Myo/pericarditis
Dilated cardiomyopathy
VHC requests reports on any generalized rash occurring within 30 days of smallpox vaccination in addition to the list above

Case definitions and additional information is found in "Surveillance Guidelines for Smallpox Vaccine (vaccinia) Adverse Reactions", MMWR February 3, 2006 / 55(RR01);1-16 http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5501a1.htm