

Army Regulation 40-562  
BUMEDINST 6230.15A  
AFJI 48-110  
CG COMDTINST M6230.4F

Medical Services

# Immunizations and Chemoprophylaxis

Headquarters  
Departments of the Army,  
the Navy,  
the Air Force,  
and the Coast Guard  
Washington, DC  
29 September 2006

**UNCLASSIFIED**

# ***SUMMARY of CHANGE***

AR 40-562/BUMEDINST 6230.15A/AFJI 48-110/CG COMDTINST M6230.4F  
Immunizations and Chemoprophylaxis

This major revision dated 29 September 2006--

- o Describes role for the Military Vaccine Office (para 1-4d).
- o Describes standards for military immunization delivery, including quality improvement mechanisms (para 2-1 and app B).
- o Establishes that electronic immunization tracking systems are the preferred record for immunization data (para 2-7).
- o Provides guidance on managing Service personnel who lose immunization records (para 2-7c).
- o Describes a procedure for dispersing immunization during initial military training into 2 clusters, the first to reduce imminent risk of contagious disease in settings of intimate or household contact and the second for other vaccine-preventable diseases (para 3-1).
- o Describes a procedure for giving credit for immunization documented before military Service (para 3-1b).
- o Describes procedure for abiding by regulations for vaccines and other products administered in investigational new drug status or under emergency use authorization (chaps 7 and 8).

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Effective 29 October 2006


## Medical Services

### Immunizations and Chemoprophylaxis

By Order of the Secretary of the Army, Navy, Air Force, and Coast Guard:

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*Director, Health and Safety*

**History.** This publication is a major revision.

**Summary.** This regulation for immunization and chemoprophylaxis updates quality standards for immunization delivery; establishes electronic immunization tracking systems as the preferred immunization record; provides guidance for lost immunization records, immunization credit for pre-existing immunity, and complying with regulations for vaccines and other products administered in investigation new drug status or in accordance with emergency use authorization; describes dividing initial entry immunization into 2 clusters; and describes the role of the Military Vaccine Office.

**Applicability.** This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve unless otherwise stated. It also applies to the following: Uniformed Departments of the Navy, Air Force, and Coast Guard (including the active and reserve components of each Service); nonmilitary persons under military jurisdiction; selected Federal employees; selected employees of DOD contractors; and family members and other health care beneficiaries eligible for care within the military health care

system. This regulation is applicable during mobilization.

**Proponent and exception authority.** The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25-30 for specific guidance.

**Army management control process.** This regulation contains management control provisions and identifies key management controls that must be evaluated.

**Supplementation.** Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from HQDA. The

Surgeon General, ATTN: DASG-ZA, Skyline Place Building 6, Falls Church, VA 22041-3258.

**Suggested improvements.** Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA, The Surgeon General (DASG-ZA), Skyline Place Building 6, Falls Church, VA 22041-3258. Air Force users are invited to send comments and suggested improvements on AF Form 847 (Recommendations for Change of Publication) through channels to Headquarters, AFMSA/SGOP, 110 Luke Avenue, Suite 400, Bolling AFB, Washington, DC 20332-7050.

**Distribution.** This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

*Navy:* Ships and stations having medical department personnel.

\*This regulation supersedes AR 40-562/BUMEDINST 6230.15/AFJI 48-110/CG COMDTINST M6230.4E, dated 1 November 1995.

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## Chapter 1 Introduction

### 1-1. Purpose

This publication provides the directive requirements for the Military Vaccination Program; establishes general principles, procedures, policies, and responsibilities for the immunization program; and implements military and international health regulations and requirements.

### 1-2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

### 1-3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

### 1-4. Responsibilities

*a. Command medical authority.* The command medical authority will prescribe specific immunization and chemoprophylactic requirements for their units per requirements established by this publication and additional guidance provided by the appropriate surgeon general or United States Coast Guard (USCG), Coast Guard, Director of Health and Safety (CG-11).

*b. Combatant commanders, major command commanders, unit commanding officers, and officers-in-charge.* Combatant commanders, commanders, commanding officers, and officers-in-charge will—

(1) Ensure military and nonmilitary personnel under their jurisdiction receive required immunizations and chemoprophylaxis.

(2) Maintain appropriate international, Federal, State, and local records of all immunizations and chemoprophylaxis.

(3) Ensure personnel transferred to another command receive proper screening for and administration of appropriate immunizations and chemoprophylaxis for the area assigned, timed to provide immunity before deployment or exposure.

(4) Ensure deviations from specified immunizations are cleared or authorized by the appropriate combatant commander; surgeon general; or CG-11, USCG.

(5) Observe International Military Standardization Agreements (STANAGs), including STANAG 2037, STANAG 2491, and STANAG 3474.

*c. Medical commanders, commanding officers, and command surgeons.* Medical commanders, commanding officers, and command surgeons will—

(1) Ensure individuals administering immunizations are properly trained in accordance with Department of Defense (DOD), Service, USCG, and Centers for Disease Control and Prevention (CDC) guidelines and act within their scope of practice as determined by each Service. These training standards will include baseline and annual refresher training.

(2) Appoint, in writing, a privileged physician as medical director of any clinic or activity that administers immunizations. These physicians—

(a) Will complete appropriate training in immunization science in residence or via distance learning.

(b) Be available to address immunization issues, although it is not required that a physician be present for administration of vaccines.

(c) Approve all standard operating procedures for immunization administration in clinics or other locations where immunizations are administered.

(3) Ensure current national standards for adult and pediatric immunizations and chemoprophylactic practices are followed and local practices incorporate requirements of policies contained in references listed at appendix A.

(4) Ensure patients are evaluated for preexisting immunity or need for medical exemptions to immunization, and that granted exemptions are documented as discussed in paragraph 2-6.

(5) Ensure patients needing evaluation of adverse events after immunization are referred to appropriate medical providers, such as the medical subspecialists, including specialists in immunization health care for evaluation, consultation, or indicated intervention.

(6) Ensure compliance with policies and procedures for creating and maintaining immunization records.

(7) Ensure emergency medical response is available; that personnel who administer immunizations are trained at a minimum in basic cardiopulmonary resuscitation and the administration of epinephrine; that medical personnel practice emergency responses; and that health care providers are available to respond to adverse events resulting from immunization.

*d. The Army, as Executive Agent for the Military Immunization Program.* The Army, as Executive Agent for the Military Immunization Program and in cooperation with the military Services, will—

(1) Operate a Military Vaccine Office to provide the military Services with a coordinated source for information and education of vaccine-related activities needed in order to implement DODD 6205.3 and DODI 6205.2.

(2) Measure and analyze implementation of immunization policies as indicators of readiness, safety, and effectiveness.

(3) Support quality of standardized automated immunization tracking systems (ITS).

(4) Establish joint clinical quality standards for vaccine administration and for the education and training of personnel in vaccine health care.

(5) Review these standards annually and revise them as necessary.

*e. Each of the military Services.* Each of the military Services will provide an immunization health care capability to deliver medical specialty consultation, case management, and clinical investigation.

## **Chapter 2**

### **Program Elements and Clinical Considerations**

#### **2-1. Standards**

*a. Department of Defense policy.* The DOD policy concerning immunizations follows the recommendations of the CDC and the Advisory Committee on Immunization Practices (ACIP), unless there is a militarily relevant reason to do otherwise. Any immunizing agent licensed by the Food and Drug Administration (FDA) or the Department of Health and Human Services (DHHS) may be used, as well as immunizing agents compliant with applicable DOD investigational new drug (IND) or emergency use authorization (EUA) process. Privileged health care providers may make clinical decisions for individual beneficiaries to customize medical care or to respond to an individual clinical situation.

*b. Standards for delivery of military vaccines.* Standards for delivery of military vaccines are provided in appendix B. Military Services will abide by these standards in routine immunization delivery.

*c. Expiration date.* Immunizing agents will not be used beyond the manufacturer's potency expiration date, unless the appropriate surgeon general or CG-11, USCG authorizes extension in exceptional circumstances.

*d. Immunization intervals.*

(1) Recommended immunization schedules will not be compressed. Immunizations given at an interval shorter than the recommended interval may not provide adequate immune response and should not be counted as part of a primary series, unless part of "catchup" schedules accepted by the CDC. Once an immunization series has been started, complete it, unless a medical contraindication exists or the person is no longer susceptible or likely to be exposed to pathogen in question.

(2) Restarting an immunization series or adding extra doses is not necessary when an initial series of a vaccine or toxoid is interrupted because increasing the interval between doses in a series does not diminish the ultimate immunity obtained. Instead, give delayed doses as soon as feasible.

*e. Simultaneous immunizations.* National norms regarding simultaneous administration of vaccines will be observed.

(1) In general, to minimize injection-site discomfort, not more than 5 vaccine injections will be given on the same day. Apply this guidance in light of subparagraphs (2), (3), and (4), below.

(2) Additional immunizations are then given at an appropriate later date. A week will often suffice for inactivated vaccines. Live-virus immunizations typically are given simultaneously or at an interval of 4 or more weeks.

(3) Priority of immunization is based on relative likelihood of the various microbial threats and the existence of any vaccine-vaccine, vaccine-antibody, or vaccine-drug interactions. A starting point for prioritizing immunizations for an individual would consider microbes most likely to be encountered (for example, typhoid, hepatitis A, influenza), of greatest severity if encountered (for example, anthrax, smallpox, meningococcal, yellow fever, Japanese encephalitis, rabies), or of long-standing risk (for example, hepatitis B, tetanus-diphtheria-pertussis, poliovirus, varicella, measles-mumps-rubella (MMR)). In military training centers, contagious diseases would typically represent the most imminent threats.

(4) Prioritization (see para (3), above) is best performed by an experienced health care provider. The 5-injection threshold should only be exceeded in cases where the vaccine recipient is deploying beyond the reach of deployable medical resources, where exceptional personal exposure to infectious diseases exists, or when authorized by the physician responsible for the immunization service.

*f. Screening for immunity.* For some vaccine-preventable diseases, serologic or other tests can be used to identify preexisting immunity from prior infection or immunization that may eliminate the need for unnecessary immunization. Such testing may be adopted where it offers advantages in terms of improved care or medical economics.

#### **2-2. Logistics**

*a.* Immunizing and chemoprophylaxis agents are requisitioned in accordance with medical supply procedures.

*b.* All personnel involved with medical supply will expend sufficient resources to maintain the cold chain in vaccine delivery, ensuring appropriate storage temperatures during shipment and avoiding inappropriately low or elevated temperatures. Shipping and storage advice is available from Service medical logistics centers (for example, Class VIII Service Item Control Center).



c. To minimize the shipment of vaccines that must be stored at frozen temperatures, small stations and ships may requisition these items from a nearby military medical activity stocking the items. Requisitioning procedures and reimbursement are prescribed by the supplying activity.

### **2-3. Storage and handling**

Immunizing and chemoprophylaxis agents are stored, shipped, and handled in accordance with the pharmaceutical manufacturers' instructions as outlined in the product's package insert or other guidance.

### **2-4. Hypersensitivity or allergy**

a. Before administration of any medication, including vaccines, determine if the individual has previously shown any unusual degree of adverse reaction or allergy to it or any specific component of the vaccine or its packaging (for example, eggs, gelatin, preservatives, latex). Review the manufacturers' package inserts and reference materials for product-specific information.

b. Individuals with reported hypersensitivity are deferred from immunization or chemoprophylaxis.

(1) Refer the patient to an appropriate medical specialist for evaluation, unless the health record documents prior consultation or a specialist's recommendations (see paragraph 2-6 for discussion of medical exemptions).

(2) Document hypersensitivity to any vaccine, vaccine component, or medication on the SF 600 (Health Record-Chronological Record of Medical Care) and on the problem list. Exemptions from further immunization are entered in DOD- or USCG-approved electronic ITS, on the PHS Form 731 (International Certificate of Vaccination), the deployable health record (that is, DD Form 2766 (Adult Preventive and Chronic Care Flowsheet)), and/or in other relevant paper-based immunization records.

### **2-5. Immunizing women of childbearing potential**

A pregnancy screening test for women of childbearing potential is not routinely required before administering vaccines, including live-virus vaccines. Take the following precautions to avoid unintentional immunization with contraindicated products during pregnancy:

a. Display signs asking pregnant women to identify themselves. Discreetly ask the woman if she is or might be pregnant. If the answer is a certain "no", document this in the health record and immunize her. If the answer is "yes", defer her from immunization until her pregnancy ends, unless benefits of immunization outweigh risks in pregnancy (see para d, below and ACIP guidelines regarding immunizations indicated during pregnancy). If pregnancy status is uncertain, defer immunization until after a negative pregnancy evaluation (for example, urine or serologic test).

b. With regard to smallpox (vaccinia) vaccine, a specific pre-immunization screening form (available at <http://www.smallpox.mil/resource/forms.asp>) that assesses the date of the last menstrual period is required. For women whose last menstrual period was more than 28 days ago, a pregnancy test is recommended.

c. If a live-virus vaccine is administered, counsel the woman to avoid becoming pregnant for an appropriate interval (for example, as recommended by CDC or the vaccine manufacturer) and document that counseling in the health record.

d. If a woman is pregnant and immunization is indicated for her while she is pregnant, immunize in consultation with the woman's obstetric health care provider.

e. Breastfeeding women may be immunized in accordance with the current ACIP guidelines. At present, no immunization products are medically contraindicated in breastfeeding women. Smallpox vaccine is withheld from breastfeeding women, except in an outbreak, primarily due to the potential for contact transmission of vaccinia virus to the child.

f. If a contraindicated vaccine is inadvertently administered to a pregnant woman, report the event upon discovery to local preventive medicine and obstetric services and complete appropriate quality assurance documents. Report such cases to any applicable case registry such as the National Smallpox Vaccine in Pregnancy Registry. Contact the preventive medicine service or the Military Vaccine Office for reporting procedures.

### **2-6. Exemptions**

There are 2 types of exemptions from immunization: medical and administrative. Granting medical exemptions is a medical function that can only be validated by a health care professional. Granting administrative exemptions is a non-medical function, usually controlled by the individual's unit commander.

a. *Medical exemptions.* A medical exemption includes any medical contraindication relevant to a specific vaccine or other medication. Medical exemptions will be customized to the health of the vaccine candidate and the nature of the immunization considered. Medical exemptions may be temporary (up to 365 days) or permanent. General examples of medical exemptions include those in (1), (2), and (3), below. Standard exemption codes appear in appendix C.

(1) Underlying health condition of the vaccine candidate (for example, based on immune competence, pharmacologic or radiation therapy, pregnancy, previous response to immunization).

(2) Evidence of immunity based on serologic tests, documented infection, or similar circumstances.

(3) An individual's clinical case is complex or not readily definable. In such cases, consult appropriate medical

specialists; additional clinical support is available from medical subspecialists including specialists in immunization health care.

(4) The primary care provider or a physician specialist may grant temporary or permanent medical exemptions. If additional clinical consultation is needed to assess a patient's condition, the primary care provider will perform the initial clinical workup appropriate to the presenting symptoms and grant a temporary medical exemption pending the results of a referral to a medical specialist appropriate to the individual's clinical condition (for example, dermatology, neurology, rheumatology, allergy-immunology). Specialists in immunization health care can facilitate these referrals. Multidisciplinary consultations may be appropriate. A follow-up visit by the patient to his or her primary care provider is not required if the specialist grants a permanent medical exemption. Cases warranting permanent medical exemption due to a vaccine-related adverse event will be reported to the Vaccine Adverse Events Reporting System (VAERS). Electronic and paper health records will be annotated regarding temporary and permanent medical exemptions and the vaccines to which they apply. When no longer clinically warranted, medical exemptions will be revoked. Air Force: military members with permanent medical exemptions require a medical evaluation board and/or a flying waiver in accordance with AFI 48-123.

(5) Individuals who disagree with a provider's/consultant's exemption recommendations may be referred for a second opinion to a provider experienced in vaccine adverse-event management, such as specialists in immunization health care at a medical center.

(6) Personnel will appropriately annotate electronic ITS and paper-based health records with exemption codes denoting evidence of immunity, severe adverse event after immunization, other temporary or permanent reasons for medical exemption, and other appropriate categories.

*b. Administrative exemptions.* Standard exemption codes appear in appendix C.

(1) *Separation or retirement.* Within 180 days before separation or retirement, Service personnel may be exempt from deployment (mobility) immunizations (see app D) if the following conditions are met:

(a) They are not currently assigned, deployed, or scheduled to perform duties in a geographical area where an immunization is indicated.

(b) The commander has not directed immunization because of overriding mission requirements. Personnel meeting these requirements and desiring an immunization exemption must identify themselves to their commander. The member must have approved retirement or separation orders. Active duty personnel continuing duty in the Reserve Component (RC) are not exempted on this basis.

(2) *Thirty days or less of Service remaining.* Exemptions apply to civilian employees and contractor personnel who will leave a position subject to immunization with 30 days or less.

(3) *Religious.*

(a) For Service personnel, immunization exemptions for religious reasons may be granted according to Service-specific policies to accommodate doctrinal religious beliefs. This is a command decision made with medical and chaplain advice.

1. Requests for religious exemption must include name, rank, social security number (SSN), occupational specialty code or branch, and a description of the religious tenet or belief contrary to immunization. Army: (see AR 600-20, para 5-6). Air Force: Permanent exemptions for religious reasons will not be granted. The major command (MAJ-COM) commander is the designated approval and revocation authority for temporary immunization exemptions. Coast Guard: CG-122 is the designated approval and revocation authority for temporary immunization exemptions.

2. A military physician must counsel the applicant. The physician should ensure that the Service personnel is making an informed decision and should address, at a minimum, specific information about the diseases concerned; specific vaccine information including product constituents, benefits, and risks; and potential risks of infection incurred by unimmunized individuals.

3. The commander must counsel the individual and recommend approval or denial of the exemption request, by endorsement. The commander must counsel that noncompliance with immunization requirements may adversely impact deployability, assignment, or international travel, and that the exemption may be revoked under imminent risk conditions. The commander, in making his or her recommendation, should consider the potential impact on the individual, the unit, and the mission.

4. Forward exemption requests through command channels to the respective Service approval authority for decision. Individuals with active requests for religious exemption are temporarily deferred from immunizations pending outcome of their request. For USCG, forward through appropriate chain to G-WPM, via CG-1121.

(b) Civilian employees submit religious-exemption requests to their supervisors. Such requests will be processed in accordance with 29 CFR 1605 and component and local policies.

*c. Bargaining units.* Civilian personnel affected by this document who are members of bargaining units will be considered for exemption consistent with applicable personnel management policies.

*d. Other categories.* Administrative or medical personnel will appropriately annotate electronic ITS with exemption codes denoting separation, permanent change of station, emergency leave, missing or prisoner of war, deceased, and other appropriate categories.

## 2-7. Immunization and chemoprophylaxis records

### *a. Electronic immunization tracking systems.*

(1) For military personnel, civilian employees, and other health care beneficiaries, the DOD-approved electronic ITS are the preferred record for immunization data, including date, immunization given, dose, and identification of the person administering. Clinics and other activities administering immunizations will transmit electronic records and exemption information to (and receive updates from) a DOD-centralized repository at least weekly. Transcription of historical data from official records will occur concurrently with the implementation of electronic tracking.

(2) Electronic ITS must—

(a) Comply with the requirements of the National Vaccine Injury Compensation (NVIC) Program outlined in paragraph *d*, below.

(b) Incorporate DOD-directed levels of security, certification, and redundancy, and the requirements of the Health Insurance Portability and Privacy Act of 1986 to preclude unauthorized access to personal medical information and to survive hardware or software malfunction.

(c) Incorporate appropriate redundancy characteristics to survive hardware or software malfunction.

(d) Be capable of generating printed reports of immunization status and exemption information on both an individual and unit basis.

(3) A printed report from the electronic ITS, in PHS Form 731, SF 601 (Health Record-Immunization Record), or DD Form 2766C (Adult Preventive and Chronic Care Flowsheet) (Continuation Sheet) format, accompanied by an official clinic stamp and the authorized signature and printed name of an authenticating official, will qualify as an official paper immunization record.

(4) A printed report as identified in paragraph (3), above will suffice as a valid certificate of vaccination for international travel for active duty members of the Armed Forces as outlined in Article 36 (Ann 6) of the World Health Organization (WHO) international health regulations.

### *b. Non-electronic immunization and chemoprophylaxis records.*

(1) *Deployment records.* Transfer information regarding immunizations and chemoprophylaxis including date, product given, dose, and initials of person administering to the deployable health record (that is, DD Form 2766) or comparable approved form, either by computer-generated report or by hand. Upon return from deployment, transfer entries on the deployment record into the appropriate ITS or other electronic record system

(2) *PHS Form 731.* Prepared upon request for each member of the Armed Forces and for nonmilitary personnel receiving immunizations, including date, immunization given, dose, and initials of person administering. The form contains valid certificates of immunization for international travel and quarantine purposes in accordance with WHO international health regulations. PHS Form 731 remains in the custody of the individual who is responsible for its safekeeping and for keeping it in his/her possession when traveling internationally. Data is entered by hand, rubber stamp, typewriter, or by printout from a DOD-approved electronic immunization tracking system.

(a) *Abbreviations.* Use abbreviations for vaccines and their manufacturers conforming to the nomenclature adopted by the CDC Vaccine Identification Standards Initiative (VISI) (<http://www.cdc.gov/nip/visi/prototypes.htm#abbreviations>). When writing, the day, month, and year are listed in that order. The day is expressed in Arabic numerals, the month spelled out or abbreviated using the first 3 letters of the word, and the year expressed in Arabic numerals either by 4 digits or by the last 2 digits (for example, 14 June 1994 or 14 Jun 94).

(b) *Transcribed records.* Entries based on prior official records will include the following statement: "Transcribed from official records." Alternately, the statement may cite the specific source (for example, "Transcribed from SF 601." When entries are transcribed onto paper records, the initials of the transcriber will be included on each entry.

(c) *Supply.* PHS Form 731 is obtained through normal publication supply channels.

(d) *Stamps.* Use in accordance with instructions received from the Foreign Quarantine Division of the CDC; the appropriate surgeon general; Chief, Bureau of Medicine and Surgery; or CG-11. The USCG authorizes the use of a standard address for military members which may be stamped on the face of the PHS Form 731. Stamps are procured by local purchase as necessary.

1. *Army.* Army officers: HQDA (DAPC-PSR-R), Hoffman II, 200 Stovall Street, Alexandria, VA 22332-0400; Army enlisted: Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE-FS, 8899 East 56<sup>th</sup> Street, Indianapolis, IN 46249-5301.

2. *Navy.* Bureau of Naval Personnel, Washington, DC 20370.

3. *Air Force.* HQ AFPC/DPMDB, Randolph AFB, TX 78148.

4. *Marine Corps.* Headquarters, U.S. Marine Corps, Washington, DC 20380.

5. *Coast Guard.* Commandant, CG-11, USCG Headquarters, 2100 Second Street SW, Washington, DC 20593-0001.

(e) *Written signatures.* Written signatures must appear in appropriate spaces on each certificate; signature stamps are not valid.

(3) *SF 601 (Navy, Marine Corps, and USCG).* Prepare SF 601 in accordance with Chapter 16, NAVMED P-107,

U.S. Navy, or CG COMDTINST M6000.1 series. When prepared, SF 601 and PHS Form 731 contain the SSN as identifying data.

(4) *DD Form 2766C*. Air Force. Initiate DD Form 2766C for all personnel at the time of entry into military service.

(5) *Paper-based immunization and chemoprophylaxis records*. Individuals preparing paper-based immunization and chemoprophylaxis records will ensure that paper records match the electronic ITS.

*c. Lost immunization records*. If an individual's immunization records are lost, assume the individual received standard immunizations administered at entry into military service by the individual's accession source (for example, enlisted, Service academy, direct commission) unless there is an objective reason to believe otherwise. Do not repeat such immunizations. Base decisions for future immunizations on assumed date of last immunization (for example, individual assumed to have received tetanus-diphtheria toxoid in July 1995 would next be immunized in July 2005).

*d. National Vaccine Injury Compensation Program*.

(1) The National Childhood Vaccine Injury Act (NCVIA) of 1986 and other regulations set standards for certain immunizations. These requirements apply to U.S. vaccines containing diphtheria, tetanus, pertussis, MMR, poliovirus, hepatitis A, hepatitis B, *Haemophilus influenzae* type b, influenza, varicella, rotavirus, pneumococcal-conjugate antigens, and other vaccines recommended by the CDC for routine administration to children after the Secretary DHHS publishes a notice of coverage. For these vaccines, the patient's name; identifying number (for example, sponsor's SSN); type of vaccine; date of administration; manufacturer; lot number; and the name, address, and title of person administering the vaccine must be recorded in a permanent health record or permanent office log or file, in either paper or electronic format. The electronic ITS is the primary method of immunization documentation. Other records and management reports may be generated from the electronic immunization database, as described above. Until electronic systems are fully implemented, continue to record the information on the paper immunization record and in a permanent clinic immunization log.

(2) Personnel who administer any vaccine covered under the NVIC program, to either children or adults, will provide the vaccinee an opportunity to read the most recent relevant vaccine information statements (VISs) provided by the DHHS and an opportunity to ask questions about the vaccine. Camera-ready copies of VISs are available from State health departments or through the CDC Web site (<http://www.cdc.gov/nip/>). Translations of VISs into languages other than English are available from nongovernmental organizations (for example, Immunization Action Coalition).

(3) Personnel who administer vaccines are not required to obtain the signature of the military member, patient, or legal representative acknowledging receipt of a VIS. However, to create a record that the materials were provided, health care personnel who administer vaccines will annotate each patient's health record (for example, SF 600, SF 601, DD Form 2766C) that the VISs were provided at the time of immunization.

(4) To comply with the NCVIA of 1986 and other regulations, current versions of the VISs published by the CDC will be posted on readily accessible bulletin boards near immunization clinics and mass immunization sites. Printed copies will be provided to any individual who requests one. Further, the Military Vaccine Office Web site (<http://www.vaccines.mil>) will link to the current versions of VISs.

(5) The NCVIA requires that the following events be reported to VAERS:

(a) Any event listed in the NVIC program's vaccine injury table (<http://www.hrsa.gov/vaccinecompensation/table.htm>) that occurs within the time period specified or within 7 days, if that is longer.

(b) Any contraindicating event listed in a vaccine's package insert (that is, product labeling).

(6) In addition, VAERS accepts all reports by any interested party of real or suspected adverse events occurring after the administration of any vaccine.

(7) All DOD and USCG health care beneficiaries are eligible to file claims with the NVIC program, according to the program's procedures.

## **2-8. Jet-injection immunization devices**

*a.* The DOD and USCG withdrew needle-free multi-use nozzle jet injectors (MUNJIs) capable of 600 or more injections per hour, formerly identified within DOD supply systems as "hypodermic injection apparatus jet automatic: 115 volt or foot operated," in 1997 due to safety concerns. Their use of the same unsterile nozzle and fluid pathway to inject consecutive patients could allow transmission of bloodborne pathogens. The MUNJIs are known by the trade names Ped-O-Jet®, Med-E-Jet®, Hypospray®, and DermoJet®, among other brands, and were usually refilled quickly from attached multidose vaccine vials. These devices remain unapproved and will not be used.

*b.* A new generation of needle-free disposable-cartridge jet injectors (DCJIs) avoid the safety concerns for MUNJIs by their use of a new, disposable, sterile fluid pathway for each patient. Several are FDA-approved for distribution in the United States and approved for military use (<http://www-nehc.med.navy.mil/prevmed/251800z.txt>) in accordance with the manufacturer's current recommendations, especially with regard to infection control. Administration rates with these DCJIs are currently slow because they must be filled and loaded manually. Research and development is underway for automated pre-filling and finger-free loading and ejecting of cartridges that would make future high-speed DCJIs suitable for mass immunization programs.

## 2–9. Emergency response requirements

*a. Written plan.* Clinics or activities administering immunizations will develop and maintain a written plan for emergency response, including management of anaphylaxis and fainting.

*b. Training.* Whenever vaccines are administered, at least 1 person present must be trained and current in basic cardiopulmonary resuscitation, oro–pharyngeal airway management, and recognition and initial treatment of anaphylaxis with epinephrine.

*c. Anaphylaxis management.* Supplies necessary for emergency medical management of anaphylaxis (that is, epinephrine, oral airway) and equipment and ability to activate an emergency medical system must be immediately accessible on scene during administration of any vaccine.

*d. Observation.* The ACIP general recommendations suggest that persons be observed for 15 to 20 minutes after being immunized.

*e. Temporary flying restrictions.* Aviation personnel typically will be grounded for 12 hours after immunization, or as specified by their flight surgeon. No formal grounding documents are required for uncomplicated immunization. Personnel who previously experienced urticaria, hypersensitivity phenomena, or other unusual phenomena after an immunization will be exempt from flying duties for an appropriate interval (for example, 72 hours) as determined by the flight surgeon. Further temporary grounding may be necessary until significant side effects resolve. Air Force aircrew: All injectable immunization except Japanese–encephalitis vaccine (JEV); access to medical care on the ground is recommended for all personnel unless operational needs dictate otherwise. Japanese–encephalitis vaccine: Grounding is required for 3 days after first dose, 5 days after second dose, and 3 days after third dose; grounding reduction for critical missions may be granted by MAJCOM according to current Air Force JEV policy.

*f. Self–assessment.* Personnel experiencing adverse events that could compromise their performance will remove themselves from flying duties and notify their flight surgeon.

## 2–10. Adverse events

Describe in the individual’s health record a detailed account of severe adverse events after administering immunizing agents or other medications.

*a.* Mandatory information consists of identification, lot number, and manufacturer of the vaccine or other medication; date of administration; name and location of the medical facility; the type and severity of the event; treatment provided; and any exemption from additional doses.

*b.* The NVIC program requires health care providers to report adverse events involving vaccines to VAERS. They may use the VAERS form (Form VAERS–1 (Vaccine Adverse Event Reporting System)) or submit electronic reports via the <http://www.vaers.hhs.gov> Web site. VAERS forms and information can be obtained by calling 1–800–822–7967 or by accessing the VAERS Web site at <http://www.vaers.hhs.gov/>.

*c.* The DOD and USCG require health care providers to report adverse events involving other medications (for example, immune globulins, chemoprophylaxis agents) to MedWatch. They may use the MedWatch reporting form (FDA Form 3500 (MedWatch: The FDA Safety Information and Adverse Event Reporting System)) or submit electronic reports via the <http://www.fda.gov/medwatch/index.html> Web site. MedWatch forms and information can be obtained by calling 1–888–463–6332 or by accessing the MedWatch Web site.

*d.* Reporting requirements are as follows:

(1) Health care personnel must report adverse events resulting in hospitalization, a life–threatening event (for example, anaphylaxis), time lost from duty more than 24 hours (that is, more than 1 duty shift), an event related to suspected contamination of a vaccine vial, and an event warranting permanent medical exemption (that is, a contraindicating event). Reports are also required for the following events: anaphylaxis, brachial neuritis, encephalopathy, encephalitis, rubella–associated chronic arthritis, thrombocytopenic purpura, vaccine–strain measles infection in an immunodeficient recipient, paralytic poliomyelitis, and any other entry in the vaccine injury table maintained by the NVIC program (<http://www.hrsa.gov/osp/vicp/table.htm>). These are minimum requirements.

(2) Further, health care providers are encouraged to report other adverse events that the provider considers unexpected in nature or severity.

(3) Reports of mild expected reactions are not required (for example, low–grade, self–limited fever of less than 24 hours duration; temporary local soreness, redness, or minor swelling at the site of immunization) because they are already expected, but such reports may be submitted if the clinician or patient wishes.

*e.* Patients may also submit a VAERS or MedWatch report directly. If a patient wishes to submit a VAERS report, health care personnel will assist the patient in completing the form, regardless of professional judgment about causal association to immunization.

*f.* Attach pertinent information from the recipient’s health record to the VAERS or MedWatch report. Submit copies of the report within 7 days of adverse event recognition as follows:

(1) Send the original report form and any appropriate supporting documents to the VAERS or MedWatch office.

(2) Retain 1 copy for the Clinical Quality Management Program at the reporting medical unit, which will typically involve the unit’s Pharmacy and Therapeutics Committee.

(3) File a copy of the VAERS or MedWatch report in the patient's individual health record or annotate the relevant information on the report within the health record.

(4) Submit 1 copy to the appropriate disease-control authority according to current contact instructions—

(a) *Army.* Army Medical Surveillance Activity.

(b) *Navy and Marine Corps.* Navy Environmental Health Center.

(c) *Air Force.* Air Force Institute for Operational Health.

(d) *Coast Guard.* Commandant, CG-1121.

g. Immediately notify the Defense Medical Standardization Board via e-mail message, if contamination or other serious problem with a vaccine vial or lot is suspected. Suspend usage, but quarantine and retain all such opened or unopened vials or lots under appropriate storage conditions pending further investigation and disposition instructions.

h. An adverse reaction to a DOD-directed immunization in Service personnel is a line-of-duty condition. Military treatment facility (MTF) commanders will provide full access to RC members for evaluation and treatment of adverse events potentially related to DOD-directed immunizations. Reserve Component unit commanders will inform their members that they may seek medical care for such adverse events with the unit providing assistance and information related to pay status and compensation issues. Each of the military Services will provide an immunization health care capability to deliver medical specialty consultation, case management, and clinical investigation (also see para 1-4d). Any necessary documentation, including line-of-duty determinations, will be completed after the Guardsman or Reservist is evaluated and, if required, treated. In no case will such evaluation or treatment be denied or delayed pending line-of-duty determination. If additional health care is required after the initial visit and a line-of-duty determination has established a Service connection, a notice of eligibility must be completed in accordance with DODD 1241.1.

## **2-11. Program evaluation**

a. *General requirements.* Each Service will develop appropriate quality improvement mechanisms to ensure immunizations and chemoprophylaxis agents are administered in accordance with this publication.

b. *Program assessment.* Military treatment facilities and commands storing health records will review immunization and chemoprophylaxis practices at least annually to ensure compliance with current standards of care and documentation and as a measure of medical readiness and health promotion. This will include self-assessment of the vaccine coverage level of supported populations (for example, military units, preschool children, influenza immunization of beneficiaries 50 years or older, pneumococcal immunization of patients with diabetes). Commands will track performance over time to progressively improve vaccine coverage.

c. *Measure of coverage.* Military treatment facilities and commands will conduct a review of the adequacy of immunization coverage among supported populations at least annually.

## **2-12. Blood donation**

For timing of immunization with regard to blood donation, clinicians will consider the policies of the Armed Services Blood Program Office (<http://www.militaryblood.DOD.mil>).

# **Chapter 3**

## **Personnel Subject to Immunization**

### **3-1. Military personnel**

a. *Accessions.* Service accessions include Service personnel in enlisted initial entry training, Reserve Officer's Training Corps (ROTC), Officer's Candidate School, academy preparatory school, Service academy, Officer Indoctrination School, other officer accession programs, and officers who are directly commissioned.

b. *Earlier immunizations.* When determining the immunization needs of accessions, give credit for immunizations appropriately documented earlier in life (for example, data from electronic immunization registries maintained by State health departments). Immunize if the primary series is incomplete, if a booster immunization is needed, or if the Service personnel has no serologic or historic evidence of immunity. Complete multiple-dose immunization series according to the recommended schedule as soon as possible. Except in an outbreak setting or for individual clinical purposes, immunization records will not normally be screened after completion of initial training with regard to MMR, poliovirus, or varicella vaccines.

c. *Enlisted accessions.* Enlisted accessions may be scheduled for immunizations in 2 or more clusters, as long as all appropriate immunizations are administered. Their immunity requirements appear in subparagraphs (1) and (2), below.

(1) *First cluster.* The first cluster of immunizations is administered, if susceptible, before or at the beginning of collective training (that is, initial entry training, basic military training) to protect against pathogens that represent an imminent risk of contagious disease in settings of close contact: adenovirus (when licensed); influenza (once per

season); meningococcal; MMR; and varicella (if susceptible). Pneumococcal vaccine may be administered if warranted epidemiologically.

(2) *Second cluster.* The second cluster of immunizations may be administered, if susceptible, in the first or second half of basic military training, during advanced individual training, or upon arriving at the first duty station to protect against travel and other military risks. These immunizations include: hepatitis A, hepatitis B, influenza (once per season), poliovirus, and tetanus–diphtheria (preferably with pertussis vaccine). For Coast Guard, additionally, yellow fever. For personnel needing yellow fever immunization based on their next duty assignment, administration toward the end of the training cycle is preferred. Live–virus immunizations follow at least 28 days after earlier live–virus immunizations.

*d. Reserve Officer's Training Corps cadets and midshipmen.* The ROTC cadets and midshipmen and similar officer candidates who are ordered or called to active duty or active duty for training. The immunization needs of these cadets, midshipmen, and candidates will be assessed before they arrive at ROTC or similar training camps; immunizations will be entered into a DOD–approved electronic ITS. Unless documentation of immunization or immunity can be transferred into military records, ROTC cadets will receive vaccines at their training camps to prevent MMR, varicella, hepatitis A, hepatitis B, tetanus–diphtheria (preferably with pertussis vaccine), and poliomyelitis. These immunizations may be split into 2 clusters as described above. Cadets who travel overseas as part of their training will receive immunizations according to geographic risk analysis.

*e. Service academy cadets and midshipmen.* Unless documentation of immunization or immunity can be transferred into military records, cadets and midshipmen will receive vaccines to prevent meningococcal disease, MMR, varicella, hepatitis A, hepatitis B, tetanus–diphtheria (preferably with pertussis vaccine), influenza (seasonal), and poliomyelitis. These immunizations may be split into 2 clusters as described above. Cadets who travel overseas as part of their training will receive immunizations according to geographic risk analysis.

*f. Entry–level officers.* Commissioned and warrant officers will be screened for immunization status during precommissioning physical examinations or when entering military training programs (for example, officer basic courses). If needed, they will receive vaccines to prevent MMR, varicella, hepatitis A, hepatitis B, tetanus–diphtheria (preferably with pertussis vaccine) influenza (seasonal), and poliomyelitis. These immunizations may be split into 2 clusters as described above. Immunizations will be entered into a DOD–approved electronic ITS.

*g. Active duty personnel.* Active duty personnel will be immunized in accordance with appendix D or as supplemented in official notices posted at the Military Vaccine Office Web site, <http://www.vaccines.mil>. During military service, active duty personnel shall receive or be up–to–date on immunizations for hepatitis A, influenza, and tetanus–diphtheria (preferably with pertussis vaccine). For Marine Corps: additionally, yellow fever. For USCG: additionally, hepatitis B.

*h. Reserve Component.* Reserve Component personnel will be immunized in accordance with appendix D or as supplemented in notices posted at <http://www.vaccines.mil> and will receive the same immunizations as active duty personnel. Reserve Component members must be in a duty status to receive required immunizations. For Marine Corps: additionally, yellow fever.

*i. Occupational risk.* Military members at occupational risk will receive appropriate vaccines per appendix D or as supplemented in notices posted at <http://www.vaccines.mil>. Special populations at occupational risk for vaccine–preventable diseases not listed in appendix D will be immunized per Federal, Service, or local occupational medicine guidance.

*j. Service–specific requirements.*

(1) *Army.* Typhoid and yellow fever immunization are required for alert forces defined by Forces Command (FORSCOM) as division–ready brigades, including attached command and control packages, combat support packages, combat service support packages, and other units approved by the FORSCOM commander.

(2) *Navy and Marine Corps.* Yellow fever immunization is required for all Marine Corps personnel and for all Navy personnel assigned to Marine Operating Forces. Additionally, yellow fever immunization is required for Navy personnel assigned to Navy units subject to deployment within 10 days of notification into land areas where yellow fever is endemic. Typhoid immunization is required for alert forces defined as: fleet units deployed on a scheduled or situational basis to any foreign country (except Canada). These units include Navy and military sealift command ships (including civilian mariners), aircraft squadrons, Marine operating forces, construction battalion detachments, and naval special warfare personnel. This includes medical department personnel assigned to Mobile Medical Augmentation Readiness Teams and other naval personnel, including members of Reserve units, subject to foreign deployment within 10 days of notification.

(3) *Air Force.* Initial and subsequent immunization against meningococcal disease, typhoid fever, and yellow fever are required only for operational units specifically identified by the MAJCOM surgeon.

(4) *Coast Guard.* Yellow fever immunization is required for all personnel in units specifically identified by the CG–11. Typhoid vaccine is required for all forces whose operational mission requires deployment to typhoid–endemic areas (for example, Central and South America) and who will have prolonged exposure to potentially contaminated local food and drink.

*k. Geographic (travel) requirements.*

(1) Each Service preventive medicine authority maintains current health threat assessments based on disease prevalence in specific geographical regions using Federal, DOD, USCG, and other relevant sources of information. These assessments are disseminated to units within their respective jurisdictions.

(2) Installations and deployed units report disease occurrence through appropriate unit and/or medical lines of communication.

(3) Combatant commanders, in coordination with the appropriate surgeons general or CG-11, establish specific immunization requirements based on a disease threat assessment. These requirements may differ from standard Service immunization policies for personnel entering their area of responsibility to participate in exercises or other operational missions. Personnel on official deployment or travel orders will be immunized by local medical support in accordance with the specific guidance established by the combatant commander before departure.

(4) For short notice travel or deployments requiring vaccines given in a multidose series, administer the first dose of the basic series. Administer as many of the subsequent doses as time permits. If the series cannot be completed before departure, complete it upon arrival. Completion before departure is the goal. Inform the patient that in order to obtain optimal immunity, the series must be completed by receiving additional doses.

(5) For quarantine, entry, and reentry requirements, follow the provisions of U.S. Foreign Quarantine regulations concerning entry or reentry of military and nonmilitary personnel into the United States or its commonwealths, territories, and possessions.

*l. Other Uniformed Service personnel.* Members of other Uniformed Services are authorized immunizations according to their occupation, official duties, travel plans, health status, or other relevant factors.

### **3-2. Civilian employees and contracted workers**

*a. Emergency-essential and Federal civilians.* Emergency-essential civilian employees and Federal civilian employees who deploy in support of Armed Forces. Those civilian employees and other groups having status equivalent to deployable forces serving under the auspices of the military Services are provided the same immunizations as military personnel without charge at military activities. In accordance with DODD 1404.10, emergency-essential employees will be notified that they may be required to take immunizations as a condition of employment. A record of notification will be filed with a signed DD Form 2365 (DOD Civilian Employee Overseas Emergency-Essential Position Agreement). Applicable vacancy announcements and position descriptions will note obligations to receive immunizations. Emergency-essential employees have the same access as military personnel to treatment and necessary medical care related to adverse events after immunization, consistent with applicable occupational health program requirements.

*b. Other Federal civilian employees and contracted workers.*

(1) *Other employees engaged in foreign duty under military sponsorship.* Federal civilian employees will receive country-specific immunizations without charge at military activities upon presentation of official orders or authorization. Area preventive medicine authorities are consulted for recommendations applicable to specific areas. People declining immunizations required for entry into foreign countries are referred to the appropriate authority for counseling. Document counseling in the health record and note that omission of certain immunizations may subject them to adverse action according to host country policies, which could include compulsory immunization, detention, quarantine, or denial of entry.

(2) *Civilian employees at occupational risk for vaccine-preventable disease.* Federal civilian employees at risk of exposure to an infectious disease associated with their occupation will receive appropriate immunizations without charge at military activities. Immunizations will be administered upon recommendation of the responsible occupational medicine authority.

(3) *Civilian health care employees.* Susceptible or occupationally exposed health care employees (including volunteers) who have direct contact with patients will receive appropriate immunization against communicable diseases unless a current immunization, a protective titer, or a medical exemption is documented. This policy applies to all health care settings, regardless of age or sex of the health care employee. Employees, including volunteers, who have contact with or potential exposure to human blood or blood products (whether from patient care, laboratory, or other health care settings) are provided hepatitis B virus vaccine in accordance with the local bloodborne pathogen exposure-control plan.

(4) *Department of Defense schoolteachers, daycare center workers, and children attending DOD-sponsored schools and daycare centers or similar facilities on military installations.* As a condition of employment or attendance at these facilities, schoolteachers, childcare center workers, volunteers, and children attending DOD-sponsored primary and secondary schools, childcare centers, or similar facilities are administered appropriate vaccines against communicable diseases unless already immune (based on documented receipt of vaccine series or physician-diagnosed illness) or medically/administratively exempt. For rubella, immunity is based only on documentation of immunization or laboratory evidence of immunity. Administer influenza vaccine annually to schoolteachers, daycare workers, and volunteers. In addition, all other age appropriate ACIP-recommended vaccines for children are required unless there is documentation of previous immunization, religious exemption, or medical contraindication. Installation medical staff will collaborate with DOD school and daycare center authorities to ensure effective immunization screening procedures. Local



MTFs will appoint liaisons to these facilities to ensure understanding and compliance. For foreign-national children outside the United States, observe host country recommendations or requirements.

(5) *Employees with potential occupational exposure to wastewater or sewage.* Employees at occupational risk will receive tetanus-diphtheria toxoids (preferably with pertussis vaccine) per ACIP recommendations. Other vaccines are not routinely required based solely on occupational risk for wastewater treatment system workers, including sewage generated by medical facilities.

(6) *Productivity enhancement.* The installation or activity commander, upon the recommendation of the appropriate medical authority, will provide immunizations against diseases that may be a significant cause of lost work hours in the civilian workforce (for example, influenza). Such immunizations are voluntary and are administered without charge to the employee.

(7) *People immunized per categories above.* People immunized per categories above are authorized treatment and necessary medical care related to adverse events after immunization, consistent with applicable occupational health program requirements.

(8) *Workers collocated with Department of State.* Where workers in this category are collocated with Department of State personnel, the 2 staffs will work together in the interest of disease prevention and health promotion.

*c. Bargaining units.* For Federal employees in a bargaining unit, local management must meet applicable labor relations obligations before implementing any changes to the bargaining unit employees' conditions of employment. Civilian personnel advisory centers provide guidance on these matters.

*d. Contracted workers.* For civilian personnel working under contract to any component of the DOD or USCG, immunizations may be provided according to terms of the contract and are provided as stated in the contract agreement. Otherwise, contractors provide appropriate immunizations to their employees. When immunization is a condition of employment under the contract, contracted employees will be notified as far in advance as practical. For vaccines with limited distribution (for example, anthrax, smallpox), DOD or USCG may provide the immunizations to these workers. The contractor is responsible for work-related illnesses, injuries, or disabilities under worker-compensation programs, supplemented by existing Secretarial designee authority. Contracted health care workers are eligible for immunizations required or offered to health care employees. These immunizations are provided as stated in the contract agreement. These contracts will include specifications describing immunizations required of contracted health care workers.

*e. Biological warfare defense.* Immunization of civilian employees and contracted workers for biological warfare defense are addressed in DODI 6205.4.

*f. Emergency situations.* In emergency situations, the provisions of DODD 6200.3 apply.

### **3-3. Other populations**

*a. Family members of military personnel.* Family members receive immunizations according to current ACIP recommendations. The ACIP recommendations are available at the CDC Web site (<http://www.cdc.gov/nip>) or the Military Vaccine Office Web site (<http://www.vaccines.mil>). In addition, family members may be subject to Service-specific requirements/recommendations for immunizations applicable to the country in which they will reside while accompanying military members under military sponsorship.

*b. Family members of other Federal civilian employees and contracted workers in foreign-duty settings under military sponsorship.* These family members will receive country-specific immunizations without charge at military activities upon presentation of official orders or authorization. Area preventive medicine authorities are consulted for recommendations applicable to specific areas. People declining immunizations required for entry into foreign countries are referred to the appropriate authority for counseling. Document counseling in the health record and note that omission of certain immunizations may subject them to adverse action according to host country policies, which could include compulsory immunization, detention, quarantine, or denial of entry.

*c. Foreign nationals.* Foreign nationals who come to the United States, its territories, commonwealths, or possessions under Armed Forces sponsorship receive immunizations required for entry into the United States and by local jurisdictions. When returning to their country of origin, foreign nationals receive immunizations required by international health regulations or their country of origin. These immunizations are administered without charge at military activities upon presentation of official orders or authorization.

*d. Detainees.* The installation or activity commander, upon the recommendation of the appropriate medical authority, will provide immunizations against diseases that may be a significant cause of death or illness among detainees (for example, influenza, tetanus-diphtheria). Such immunizations are voluntary and are administered without charge to the detainee. All immunizations and chemoprophylactic medications will be annotated in the detainee's health record. Before immunization, detainees will be informed in their own language about the relative benefits and risks of the specific immunizations offered. Factors to consider in deciding which immunizations to offer detainees include their likely preexisting immunity, the anticipated length of detention, seasonal threat of infection, and other risk factors related to personal health status and living conditions.

*e. Sponsored individuals.* Other individuals who travel from, or reside outside, the United States under sponsorship of the Armed Forces receive immunizations in accordance with the requirements for family members outlined above.

*f. Overseas commander authority.* The overseas commander, commanding officer, or officer-in-charge, upon the recommendation of the appropriate medical authority, will provide immunizations against communicable diseases judged to be a potential hazard to the health of the command; such vaccines are administered without charge.

*g. Other than U.S. Forces (OTUSF).* Immunization of OTUSF for biological warfare defense are addressed in DODI 6205.4.

*h. Emergency situations.* In emergency situations, the provisions of DODD 6200.3 apply.

## **Chapter 4**

### **Specific Immunization Requirements for Department of Defense and Coast Guard Personnel**

(Also see appendix D for Service implementation.)

#### **4-1. Civilian applicability**

Certain civilian employees may be required to receive immunizations as a condition of their employment or participation in a particular assignment. In such cases, failure to voluntarily receive the immunizations may result in non-adverse or adverse action being taken (see chap 3), but in no case will immunizations be involuntarily administered.

#### **4-2. Adenovirus types 4 and 7**

*Military indication.* When FDA-licensed adenovirus vaccines are available, administer to military basic trainees as they arrive to prevent febrile respiratory disease, disease outbreaks resulting from person-to-person transmission, and lost training time.

#### **4-3. Anthrax**

*a. Military indication.* To prevent anthrax infection by any route of exposure due to spores or the bacteria *Bacillus anthracis*. Inhalational anthrax is almost uniformly fatal once symptoms develop.

*b. Military and civilian personnel.* Administer anthrax vaccine to military personnel and applicable civilians according to DOD or USCG policy for the Anthrax Vaccine Immunization Program and Service-specific implementation plans. Anthrax immunization will be conducted for personnel in geographical areas or in occupational roles designated by the Services, chairman of the Joint Chiefs, or the Office of the Secretary of Defense as being at higher threat for release of anthrax as a weapon.

*c. Occupational risk.* Administer anthrax vaccine to at-risk veterinary and laboratory workers and others at occupational risk of exposure.

#### **4-4. Cholera**

*Military indication.* When an FDA-licensed cholera vaccine to counter *Vibrio cholerae* is available, administer according to DOD policy in appropriate deployed or deploying populations. Cholera immunization is no longer required by any nation to meet international travel requirements.

#### **4-5. Haemophilus influenzae type b (Hib)**

*a. Military indication.* To prevent invasive Haemophilus disease in people who have anatomic or functional asplenia.

*b. Military and civilian personnel.* Administer 1 dose of Hib vaccine to people who do not have spleens.

#### **4-6. Hepatitis A**

*a. Military indication.* To prevent hepatitis A, an acute infection of the liver, acquired by consuming food or water contaminated with hepatitis A virus during deployment or travel to areas with poor food, water, and sewage sanitation. Hepatitis A is endemic worldwide.

*b. Military and civilian personnel.* Administer hepatitis A vaccine to all military personnel. Administer hepatitis A vaccine to all civilian personnel and contracted workers in deployed settings. Whenever possible, administer the first dose during initial entry training (for example, with the second cluster of immunizations).

*c. Occupational risk.* Hepatitis A vaccine is indicated for daycare workers, health care workers having contact with active cases, laboratory workers who are at risk of exposure, and locally designated food handlers.

*d. Product selection.* Immunization may be accomplished with single-agent hepatitis A vaccine or combined hepatitis A-hepatitis B vaccine.

#### **4-7. Hepatitis B**

*a. Military indication.* To prevent hepatitis B, an acute or potentially chronic infection of the liver that is acquired through percutaneous, sexual, and other permucosal exposure to blood and body fluids from people infected with hepatitis B virus. Hepatitis B infections occur worldwide, and some infected people maintain a chronic carrier state.

*b. Military personnel.* Unless already immune, administer hepatitis B vaccine to susceptible military personnel with

the second cluster of immunizations during initial entry training, as well as military personnel susceptible based on occupation or behavior, or deploying for more than 30 days to areas of high hepatitis B endemicity (for example, portions of Asia).

*c. Occupational risk.* Administer hepatitis B vaccine to susceptible military and civilian personnel who are at risk of exposure to bloodborne pathogens per Occupational Safety and Health Administration standards (29 CFR 1910.1030, <http://www.osha.gov/SLTC/bloodbornepathogens/index.html>). For military purposes, this includes occupational specialties involving health care workers, emergency medical technicians, mortuary affairs personnel, search and rescue specialists, correctional facility staff, and designated special operations forces. Post-immunization serologic testing may be warranted for selected personnel, according to CDC and ACIP recommendations. Document results of serologic testing in a DOD-approved electronic ITS and on the deployable health record. Follow CDC recommendations for postexposure management related to bloodborne pathogens.

*d. At-risk adults.* Recommend hepatitis B vaccine for susceptible beneficiaries who are treated for a sexually transmitted infection.

*e. U.S. Forces Korea.* For personnel on permanent change of station orders or assigned to the Korean peninsula, complete the primary series of hepatitis B immunizations. Administer at least 2 doses according to the licensed schedule before arriving in Korea, whenever possible.

*f. Serologic testing.* Post-immunization serologic testing may be warranted for selected health care workers and mortuary affairs personnel to identify non-responders to hepatitis B vaccine, according to CDC and ACIP recommendations. Document results of serologic testing in a DOD-approved electronic ITS and on the deployable health record.

*g. Product selection.* Immunization may be accomplished with single-agent hepatitis B vaccine or combined hepatitis A-hepatitis B vaccine.

#### **4-8. Influenza A and B**

*a. Military indication.* To prevent influenza A and B, which are acute febrile respiratory viral infections that can cause epidemics within military populations, especially under conditions of crowding, such as initial entry training, aboard ship, extended air transport, or deployment settings. Influenza A has the potential for pandemic spread.

*b. Military personnel.* Administer influenza vaccine annually to all active duty and Selected Reserve military personnel.

*c. Occupational risk.* Offer influenza vaccine to all other workers annually.

#### **4-9. Japanese encephalitis**

*a. Military indication.* To prevent Japanese encephalitis, a mosquito-borne viral disease, during deployments and travel to endemic areas in Eastern Asia and certain western Pacific Islands. Japanese encephalitis virus can cause an acute infection of the brain, spinal cord, and meninges with high rates of complications, chronic disability, and death.

*b. Military and civilian personnel.* Administer JEV to military personnel, civilian personnel, contracted workers, and other beneficiaries who are or will be stationed at least 30 days in rural areas of Asia where there is substantial risk of exposure to the virus, especially during prolonged field operations at night. Administer booster doses according to the manufacturer's recommendations if risk of exposure is still present. The main groups needing JEV are designated special operation units, Navy mobile construction battalions, Marine expeditionary units operating in the Western Pacific, and troops assigned or deploying to Okinawa with extended field exposure. Under normal circumstances, this immunization is not warranted for personnel assigned to or deploying to Korea. Under normal circumstances, vaccinees will not embark on international travel within 10 days of Japanese-encephalitis immunization because of the possibility of delayed allergic reactions.

*c. Alert personnel.* Administer JEV to alert personnel who would deploy within 10 days of notification to rural areas of Asia in which the disease is endemic. Administer booster doses every 3 years if still eligible to deploy to rural areas of Asia. For Air Force, only units specifically identified by the MAJCOM surgeon require immunization against Japanese encephalitis.

*d. Temporary flying restrictions.* For Air Force aircrew, grounding is required for 3 days after first dose, 5 days after second dose, and 3 days after third dose; grounding reduction for critical missions may be granted by MAJCOM according to current Air Force JEV policy. For other Services, Aviation personnel will be grounded for 12 hours after immunization (the standard procedure after any immunization) or according to the instructions of their flight surgeon. Personnel who previously experienced urticaria or hypersensitivity phenomena of any type after JEV will be exempt from flying duties for at least 3 days after first dose, 5 days after second dose, and 3 days after third dose.

#### **4-10. Measles, mumps, and rubella**

*a. Military indication.* To prevent MMR, primarily by boosting immunity acquired from childhood immunization. These 3 acute viral infections are spread by the respiratory route or person-to-person contact. In military trainee populations, each can cause disease outbreaks. Rubella usually causes a mild infection, but infection during the first trimester of pregnancy puts the fetus at high risk of congenital rubella syndrome and birth defects. Young adults may

experience more severe complications from mumps infection. All 3 diseases occur worldwide, primarily among children.

*b. Basic trainees and other accessions.* Administer MMR vaccine to susceptible basic trainees and accessions within the first 2 weeks of training.

*c. Military and civilian personnel.* Persons born in 1957 or earlier are presumed to be immune through infection. Ensure military personnel born after 1957 have received 2 lifetime doses of MMR vaccine or have positive serologic test results. Unless there is reason to suspect otherwise (for example, childhood spent in a developing country, childhood immunizations not administered), a childhood dose of MMR vaccine may be assumed. Document results of serologic testing in a DOD–approved electronic ITS and on the deployable health record. Because of the high level of childhood immunization against these diseases, do not screen immunization records with regard to measles, mumps, or rubella immunity after completion of initial training, except in an outbreak setting or for individual clinical purposes.

*d. Occupational risk.* Ensure health care workers have received 2 lifetime doses of MMR vaccine or have positive serologic test results. Unless there is reason to suspect otherwise (for example, childhood in a developing country, childhood immunizations not administered), a childhood dose of MMR vaccine may be assumed. Document results of serologic testing in a DOD–approved electronic ITS and on the deployable health record.

*e. Bivalent measles–rubella vaccine.* For personnel whose records show receipt of bivalent measles–rubella vaccine, administration of MMR vaccine to achieve immunity against mumps is not necessary as a military requirement, but may be appropriate in exceptional clinical circumstances.

#### **4–11. Meningococcal disease**

*a. Military indication.* To prevent meningitis and other systemic infection caused by the bacteria *Neisseria meningitidis*, serogroups A, C, W–135, and Y. No vaccine against serogroup B meningococci, another common pathogen, is currently licensed in the United States. Basic trainees and other military populations living in conditions of crowding are at increased risk for meningococcal infection; historically, outbreaks have occurred in training populations. Meningococcal vaccine may be indicated for deployment and travel to areas with highly endemic meningococcal disease.

*b. Basic trainees and other accessions.* Administer meningococcal vaccine to basic trainees and cadets at Service academies within the first 2 weeks of training.

*c. Military and civilian personnel.* Administer meningococcal vaccine to military personnel traveling for more than 15 days to regions subject to meningococcal outbreaks, if not administered within an appropriate booster interval. Administer meningococcal vaccine to personnel traveling to sub-Saharan Africa during the dry season (December to June), and other countries as recommended by the CDC, if not administered within an appropriate booster interval. Consult combatant command surgeons for current recommendations based on disease distribution.

*d. Alert personnel.* Administer meningococcal vaccine to personnel who would deploy within 10 days of notification, if not administered within an appropriate booster interval. For Air Force, accessions will be vaccinated. Thereafter, only units specifically identified by the MAJCOM surgeon require subsequent immunization against meningococcal disease.

*e. Other personnel.* Administer one dose of meningococcal vaccine to persons who do not have spleens.

#### **4–12. Pertussis**

Using FDA–licensed pertussis vaccines for adolescents and adults to counter *Bordetella pertussis*, immunize according to ACIP recommendations.

#### **4–13. Plague**

The causative agent of plague, *Yersinia pestis*, has been identified as a potential biological warfare agent. When an FDA–licensed vaccine is available, administer according to DOD policy in appropriate populations.

#### **4–14. Pneumococcal disease**

*a. Military indication.* To prevent pneumococcal disease due to *Streptococcus pneumoniae* in personnel who fall into a high–risk category due to age or underlying health conditions (for example, persons without spleens) or who are in high–risk situations, such as certain training populations.

*b. Basic trainees and other accessions.* If warranted, based on disease incidence, administer pneumococcal vaccine to high–risk trainees and accessions within the first 2 weeks of training based on preventive medicine guidance.

*c. Military personnel.* Administer pneumococcal vaccine to military personnel and beneficiaries who are in a high–risk category per ACIP recommendations. Administer a second dose to persons without spleens 5 years after the initial dose.

#### **4–15. Poliomyelitis**

*a. Military indication.* To prevent poliomyelitis primarily by boosting immunity acquired from childhood immunization. Poliomyelitis is acquired by person–to–person transmission through the fecal–oral route. Military and civilian

personnel deploying or traveling to areas with poor sanitation are at increased risk, although international immunization efforts have decreased poliomyelitis incidence worldwide. Only inactivated poliovirus vaccine (IPV) is available in the United States.

*b. Basic trainees and other accessions.* Administer a single booster dose of IPV to trainees and accessions. Personnel who have not received primary series must complete the series using IPV. Unless there is reason to suspect otherwise (for example, childhood spent in a developing country, childhood immunizations not administered), receipt of the basic immunizing series of IPV may be assumed.

*c. Military personnel.* Because of the high level of childhood immunization against these diseases, do not screen immunization records with regard to poliovirus immunity after completion of initial training except in an outbreak setting or for individual clinical purposes.

#### **4-16. Rabies**

*a. Military indication.* To prevent rabies after the bite of an animal suspected to be infected with rabies virus. Vaccine is given in conjunction with wound care and the administration of human rabies immune globulin. For pre-exposure immunization of people occupationally at risk of exposure to rabid animals (for example, animal handlers and certain laboratory, wildlife management, and security personnel) and people assigned long-term to regions with endemic rabies, especially in dogs and cats.

*b. Military personnel.* Administer pre-exposure rabies vaccine series to special operations personnel. Give booster doses every 2 years or when antibody concentrations indicate.

*c. Occupational risk.* Administer pre-exposure rabies vaccine series to veterinary workers, animal handlers, and security personnel who have animal control duties. Give booster doses every 2 years or when antibody concentrations indicate.

#### **4-17. Smallpox**

*a. Military indication.* In 1980, the WHO declared the global eradication of naturally occurring smallpox. Nonetheless, stocks of variola virus, the causative agent of smallpox, could be used as a biological warfare agent. Vaccinate designated military and civilian personnel according to DOD or USCG policy and Service-specific implementation plans. These include military personnel and applicable civilians who are smallpox epidemic response team members, assigned to medical teams at hospitals and clinics, or assigned to designated forces that constitute mission-critical capabilities. Vaccination will be conducted for personnel based on geographic location or occupational role designated by the Services, Chairman of the Joint Chiefs, or the Office of the Secretary of Defense as being at higher threat for exposure to smallpox. These roles will include laboratory workers and designated special-mission units.

*b. Training and education.* Military and civilian personnel eligible to receive smallpox vaccine will be educated before immunization regarding criteria for exemption from immunization, expected response at the vaccination site, vaccination-site care, risks of spreading vaccinia to close contacts, and other relevant topics.

*c. Screening.* A specific screening form posted at <http://www.smallpox.mil> will be used to identify persons with personal or household contraindications to smallpox vaccination. Screening will include assessing pregnancy status and recency of testing for human immunodeficiency virus infection. In the event of a smallpox outbreak, "permanent" exemptions may be rescinded according to individual risk of exposure to variola virus.

*d. Vaccination.* Internal MTF and command clinical quality management programs will have mechanisms to confirm that vaccinators demonstrate proper vaccination technique.

*e. Post-vaccination site care.* Appropriate care will be taken to prevent the spread of vaccinia virus from a vaccinee's vaccination site. MTFs will monitor the vaccination sites of vaccinated health care workers (for example, by operating site-care stations), promote effective bandaging, and encourage scrupulous hand washing.

*f. Post-vaccination evaluation (take check).* Assessment and documentation of response to vaccination is required for health care workers and members of smallpox response teams who would travel into a smallpox outbreak area. Others receiving smallpox vaccine also should have their vaccination response evaluated and recorded. Documentation will include entry into a DOD-approved electronic ITS.

#### **4-18. Tetanus, diphtheria, and pertussis**

*a. Military indication.* To prevent tetanus, diphtheria, and pertussis, primarily by boosting immunity acquired from childhood immunization. Tetanus is an acute illness caused by an exotoxin of *Clostridium tetani*, a bacteria that grows at the site of wounds contaminated with its spores. The *C. tetani* spores are ubiquitous in the environment worldwide. Diphtheria is an acute disease caused by a cytotoxin of the bacteria *Corynebacterium diphtheriae*. Diphtheria occurs worldwide. Pertussis is an acute illness caused by the bacteria *Bordetella pertussis*. Available vaccines include bivalent tetanus-diphtheria (Td) toxoids and Td combined with acellular pertussis (Tdap) antigens. The Tdap is preferred so that vaccinees sustain immunity to pertussis.

*b. Basic trainees and other accessions.* Individuals with previous history of Td immunization receive a booster dose of Td or Tdap upon accession. For those individuals lacking a reliable history of prior immunization, initiate a primary series of Td toxoid according to ACIP guidelines. Unless there is reason to suspect otherwise (for example, childhood

spent in a developing country, childhood immunizations not administered), receipt of the basic immunizing series may be assumed.

*c. Military and civilian personnel.* Administer booster doses of Td or Tdap to all personnel every 10 years.

*d. All personnel.* Following ACIP wound-management guidelines, in the treatment of contaminated wounds, administer a booster of Td or Tdap if more than 5 years have elapsed since the last dose of Td or Tdap. Tetanus immune globulin is warranted in treating contaminated wounds if the patient received fewer than 3 doses of a vaccine containing tetanus toxoid at any time or if receipt of a prior basic immunizing series is unlikely.

#### **4–19. Typhoid fever**

*a. Military indication.* To prevent typhoid fever, a systemic bacterial disease acquired by consuming food or water contaminated with *Salmonella typhi*, during deployment or travel to typhoid-endemic areas and other areas with poor sanitation.

*b. Basic trainees and other accessions.* Not routinely administered except for personnel with overseas assignment orders.

*c. Military and civilian personnel.* Administer typhoid vaccine to military personnel before overseas deployment to typhoid-endemic areas.

*d. Alert personnel.* Administer typhoid vaccine to alert personnel prepared for deployment to typhoid-endemic areas or personnel who would be exposed to potentially contaminated local food and drink. Administer booster doses per immunization schedule. For Air Force, only units specifically identified by the MAJCOM surgeon require initial and subsequent immunization against typhoid fever.

#### **4–20. Varicella**

*a. Military indication.* To prevent varicella (chickenpox) among susceptible military members, especially basic trainees, cadets at Service academies, officer trainees, and special operations personnel, living in military environments conducive to person-to-person spread of respiratory diseases (for example, barracks, ships). Although varicella is a common childhood disease, adults may experience more severe illness and have higher complication and case-fatality rates.

*b. Basic trainees and other accessions.* Administer varicella vaccine to susceptible trainees and other accessions within the first 2 weeks of training. Serologic screening of trainees is the preferred means of determining those susceptible to varicella infection and in need of immunization. If serologic screening is not feasible, people may be questioned for indicators of preexisting immunity. Identify those people who do not have a personal history of varicella disease, documentation of prior varicella immunization, or documentation of immunity based on serologic testing as susceptible. Document results of serologic testing in a DOD-approved electronic ITS and on the deployable health record. Adults and adolescents require 2 doses of varicella vaccine given 4 to 8 weeks apart.

*c. Health care workers.* Administer varicella vaccine to susceptible health care workers. Determine susceptibility as noted above for trainees. Routine post-immunization testing for antibodies to varicella is not recommended.

*d. Other susceptible adults.* Offer varicella vaccine to other susceptible persons, especially nonpregnant women of childbearing age and men living in households with young children.

#### **4–21. Yellow fever**

*a. Military indication.* To prevent yellow fever, a mosquitoborne viral disease, and to meet international health requirements during deployment or travel to yellow-fever-endemic areas.

*b. Military and civilian personnel.* Administer yellow fever vaccine to military personnel traveling to or transiting through yellow-fever-endemic areas. For Marine Corps, all personnel. For Coast Guard, all accessions.

*c. Alert personnel.* Administer yellow fever vaccine to alert personnel prepared for deployment to yellow-fever-endemic areas. Administer booster doses per immunization schedule. For Air Force, only units specifically identified by the MAJCOM surgeon require initial and subsequent immunization against yellow fever. For Navy, administer to all personnel assigned to Marine Operating Forces and those assigned to Navy units subject to deployment within 10 days of notification into land areas where yellow fever is endemic.

*d. Other personnel.* Administer yellow fever vaccine to personnel traveling to or transiting through yellow-fever-endemic areas.

## **Chapter 5 Chemoprophylaxis**

### **5–1. General**

*a. Chemoprophylaxis.* This section reviews military relevant diseases and associated chemoprophylaxis guidelines. Chemoprophylaxis is defined here as the administration of medication before, during, or after possible exposure to an

infectious agent, to prevent either infection or disease. Command medical officers will review indications for use and potential adverse effects of specific chemoprophylactic medications before use. Consult current authoritative recommendations (for example, CDC, ACIP, Armed Forces Medical Intelligence Center, *Control of Communicable Diseases Manual*) and observe instructions from the relevant combatant command surgeon (who will consult with the relevant preventive medicine authority) for the use of chemoprophylactic agents. The following classes of chemoprophylaxis are not addressed in this document:

(1) Chemical warfare-related chemoprophylaxis (see the current version of *Medical Management of Chemical Casualties*, published by the U.S. Army Medical Research Institute of Chemical Defense).

(2) Medical therapy for tuberculosis infection (see publications from CDC, the American Thoracic Society, the Advisory Council for the Elimination of Tuberculosis, and similar authorities).

(3) Radiation-related chemoprophylaxis (for example, potassium iodide, granisetron, or Prussian blue).

(4) Other forms of prevention involving nonbiological medications (for example, calcium, aspirin, vitamins).

*b. Packaging.* Chemoprophylaxis agents will be dispensed to individuals in child-resistant containers (consistent with the Poison Prevention Packaging Act, 15 USC 1471–1476) or unit-of-use packaging. Packaging will be appropriate to keep the medication clean and dry.

*c. Labeling.* Chemoprophylaxis agents will be dispensed to individuals in packages that contain the name of the product, directions for proper use, and the name of the person to whom the medication was dispensed.

## 5–2. Anthrax

*a. Military indication.* Antibiotics have been shown to increase survival when used after exposure to anthrax and before onset of symptoms (that is, postexposure prophylaxis or empiric treatment). The combatant commander will direct such use.

*b. Chemoprophylaxis.* Consider doxycycline or ciprofloxacin. For children, consider amoxicillin suspension. Adapt according to current authoritative recommendations.

## 5–3. Group A streptococcal disease

*a. Military indication.* Outbreaks of group A streptococci can spread rapidly in groups having especially close contact, such as military populations during contingency operations and during certain types of training. It may be required to administer penicillin prophylactically to the entire group to terminate disease transmission.

*b. Chemoprophylaxis.* Consider penicillin G benzathine (IM, also known as *Bicillin LA*) or penicillin VK (oral). Administration prophylactically to an entire group may be needed to terminate disease transmission.

*c. Customized approach.* Because of local epidemiologic factors, each Service will develop policies for surveillance and prophylaxis of streptococcal disease at training centers.

## 5–4. Influenza A and B

*a. Military indication.* Influenza can be a significant cause of morbidity in a susceptible population and can degrade mission capability. Oseltamivir is effective in the chemoprophylaxis of both influenza type A and type B. Amantadine and rimantadine are effective in the chemoprophylaxis of influenza A, but not influenza B. Consider antiviral therapy if available vaccine does not antigenically match circulating strains or if an outbreak occurs early in the season before widespread immunization. Zanamavir has been shown to be effective in treatment, but not prophylaxis, of both influenza type A and type B.

*b. Chemoprophylaxis.* Consider amantadine, rimantadine, or oseltamivir. Adapt according to current authoritative recommendations.

## 5–5. Leptospirosis

*a. Military indication.* Leptospirosis can cause morbidity in personnel exposed to contaminated water sources. Doxycycline is effective in preventing leptospirosis in exposed military personnel during periods of high exposure.

*b. Chemoprophylaxis.* Consider doxycycline.

## 5–6. Malaria

*a. Military indication.* Malaria has caused morbidity and mortality in military populations for centuries. Military operations often occur in areas of the world where malaria is endemic. Medical commanders will designate trained staff to provide comprehensive malaria prevention counseling regarding mosquito avoidance, personal protective measures (for example, clothing, repellents, bed nets) and chemoprophylaxis to military and civilian personnel considered to be at risk of contracting malaria. Counseling will include instruction on how to take prescribed anti-malarial medications, the importance of compliance with the prescribed medication schedule, information about potential adverse effects, and the need to seek medical care if these adverse effects occur. Detailed resources are available at <http://www.cdc.gov/travel>.

*b. Chemoprophylaxis.* The Services or the combatant command surgeon determine specific chemoprophylactic regimens, typically with advice from the Armed Forces Medical Intelligence Center, for the area of operations based on

degree and length of exposure and the prevalence of drug resistant strains of *Plasmodia* in the area(s) of travel. These regimens take into consideration reports of malaria activity reported by CDC and WHO. Anti-malarials are prescription medications to be individually dispensed in labeled, child-resistant containers. Health care providers must document malaria chemoprophylaxis prescriptions in the Service personnel's health record whenever these medications are prescribed. This recordkeeping should include the member's electronic medication profile (for example, Composite Health Care System II), whenever possible.

*c. Pre-primaquine testing.* Test people requiring primaquine chemoprophylaxis for glucose-6-phosphate dehydrogenase (G6PD) deficiency before issuing a prescription for primaquine phosphate for terminal malarial prophylaxis. Because G6PD deficiency remains constant over time, a single screening test is sufficient. Permanently record G6PD test results in the health record and on the deployable health record. If a G6PD-deficient person has had a significant, prolonged exposure to malarial parasites that have a liver stage (for example, *Plasmodium vivax*, *Plasmodium ovale*) and it is determined that they must receive primaquine, provide primaquine only under the direct supervisory care of the treating physician.

### **5-7. Meningococcal disease**

*a. Military indication.* Meningococcal disease can result in morbidity and potential mortality in populations with crowded conditions. Chemoprophylaxis has been shown to prevent disease when administered postexposure to susceptible people.

*b. Chemoprophylaxis.* For intimate or household contacts of meningococcal disease cases, consider rifampin, ceftriaxone, ciprofloxacin, or sulfadiazine.

### **5-8. Plague**

*a. Military indication.* Plague has been identified as a potential biological warfare agent, especially with regard to inducing pneumonic plague. There is no licensed vaccine that is effective against pneumonic plague. Provide chemoprophylaxis to persons potentially exposed to cases of pneumonic plague.

*b. Chemoprophylaxis.* Consider tetracycline, doxycycline, or chloramphenicol.

### **5-9. Scrub typhus**

*a. Military indication.* Spread by the bite of infective larval mites. May be a source of morbidity in populations encountering primitive field conditions.

*b. Chemoprophylaxis.* Consider doxycycline.

### **5-10. Traveler's diarrhea**

*a. Military indication.* Diarrhea can have a significant impact on military operations when deploying to various locations around the world. Strict food and water discipline is the preferred means of prevention. However, for people going to high-risk areas where food and water discipline is unreasonable or impossible, consider chemoprophylaxis.

*b. Chemoprophylaxis.* Consider ciprofloxacin or other quinolones. An alternative to chemoprophylaxis is to prescribe medication for very early treatment, withholding administration of the first dose until the onset of diarrhea.

### **5-11. Tuberculosis**

See Service-specific policies and regulations for tuberculosis surveillance, chemoprophylaxis, and treatment guidelines.

## **Chapter 6 Biological Warfare Defense**

### **6-1. Responsibilities**

*a.* The combatant commanders, annually and as required, provide the Chairman of the Joint Chiefs of Staff with their assessment of the biological warfare threats to their theaters.

*b.* The President of the Armed Forces Epidemiological Board, in consultation with the DOD Executive Agent and the Secretaries of the military departments, annually and as required, identifies to the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) vaccines available to protect against validated biological warfare threat agents and recommends appropriate immunization protocols and/or chemoprophylaxis.

### **6-2. Procedures**

The DOD Immunization Program for Biological Warfare Defense is conducted as follows:

*a.* The combatant commanders, annually and as required, provide the Chairman of the Joint Chiefs of Staff with their assessment of the biological warfare threats to their theater.

*b.* The Chairman of the Joint Chiefs of Staff, in consultation with the combatant commanders; the chiefs of the



military Services; and the Director, Defense Intelligence Agency, annually validates and prioritizes the biological warfare threats to DOD personnel and forwards the threat list to the DOD Executive Agent through the ASD(HA).

c. Within 30 days of receiving the validated and prioritized biological warfare threat list from the Chairman of the Joint Chiefs of Staff, the DOD Executive Agent, in consultation with the Secretaries of the military departments and the President of the Armed Forces Epidemiological Board, provides recommendations to the ASD(HA) on vaccines and immunization protocols necessary to enhance protection against validated biological warfare threat agents.

d. Within 30 days of receiving the coordinated recommendations of the DOD Executive Agent, the ASD(HA) directs the Secretaries of the military departments to begin immunization of the specified DOD personnel against specific biological warfare threat agents. The ASD(HA) will coordinate with and obtain approval from the Secretary or Deputy Secretary of Defense before issuing the appropriate direction.

## **Chapter 7**

### **Vaccines and Other Products in Investigational New Drug Status**

#### **7-1. Purpose**

For infectious disease threats for which the only available vaccine or chemoprophylaxis product is in an IND status, the IND product must be administered in full accordance with FDA regulations at 21 CFR Parts 50 and 312, as well as 10 USC 1107, Executive Order 13139, and DODD 6200.2. DOD may require the use of products that have not been approved or licensed for commercial marketing as force health protection measures in combat settings, other military operations, peacekeeping, or humanitarian missions. DOD will provide comparable access to IND products to military personnel, civilian personnel, contracted workers, and beneficiaries based on the health risk to the people involved.

#### **7-2. General guidance on IND products**

Combatant commanders must request approval from the Secretary of Defense to use INDs for force health protection. If the member's use of an IND product is voluntary, the product must be administered with documented informed consent in accordance with a protocol approved by the FDA for IND product use. A vaccine, antibiotic, or other product in an IND status may be mandatory for military members, if the President of the United States has approved a waiver of the requirement for informed consent. Under 10 USC 1107, only the President has the authority to grant a waiver of the requirement that a military member provide prior consent to receive an IND or a drug unapproved for its applied use in connection with the member's participation in a particular military operation. The President must determine, in writing, that obtaining consent (1) is not feasible, (2) is contrary to the best interests of the member, or (3) is not in the interests of national security. The requirement for informed consent may not be waived for civilian personnel, contracted workers, and beneficiaries.

#### **7-3. Health recordkeeping requirements for IND products**

All IND vaccines or chemoprophylaxis products that are administered to a military member, whether with the member's informed consent or with an approved waiver of informed consent, must be recorded in the individual's permanent health record and/or other paper or DOD-approved electronic ITS. For vaccines, the documentation will be that required for other vaccines with an annotation "IND" with the vaccine name. This recordkeeping requirement is in addition to any recordkeeping requirements of the FDA-approved IND protocol. The requirement for recordkeeping applies to IND vaccines, antibiotics, and other medications in IND status.

#### **7-4. Information requirements for investigational new drug products**

Any recipient of an IND vaccine or chemoprophylaxis product must receive the information (for example, briefing, individual counseling, information statements) required by the FDA-approved IND protocol. Full compliance with this requirement is extremely important whether the IND product is voluntary or mandatory.

#### **7-5. Coordination**

The Army, as the Executive Agent for the Immunization Program for Biological Warfare Defense, maintains a program office at the U.S. Army Medical Materiel Development Activity (USAMMDA) to execute oversight and coordination of the use of IND products for Force Health Protection.

## **Chapter 8**

### **Vaccines and Other Products Used Under Emergency Use Authorization**

#### **8-1. General**

Under section 564 of the Food Drug and Cosmetic Act (21 USC 360), some drugs, vaccines, or devices that have not

been approved or licensed by the FDA through the regular drug approval process (or not approved for an intended use) may be used as medical countermeasures to chemical, biological, radiological, or nuclear (CBRN) agents or threats if the FDA grants an EUA. This EUA authority is an alternative to the otherwise applicable requirement to file an IND application and follow IND rules (see chap 7) to use such unapproved drugs as CBRN medical countermeasures.

## **8-2. Criteria**

In general, the FDA may grant an EUA for up to 12 months, with potential renewal, based on the following steps:

*a.* The Secretary of Defense or his designee has determined that there is a military emergency or significant potential for a military emergency relating to a particular CBRN agent or threat.

*b.* The Secretary of DHHS declares an emergency based on the Secretary of Defense's determination.

*c.* The Secretary of DHHS determines—

(1) The vaccine or drug may be effective in diagnosing, treating, or preventing that disease or condition.

(2) The known and potential benefits of the vaccine or drug outweigh the known and potential risks; and

(3) There is no adequate, approved, and available alternative medical countermeasure.

*d.* The duration of authorization corresponds to the duration of the emergency or significant potential for an emergency.

## **8-3. Refusal options**

The FDA may decide that potential recipients of a drug under an EUA should have the option to refuse it. The President may waive this option for military personnel.

## **8-4. Health recordkeeping requirements for emergency use authorization products**

All EUA vaccines or chemoprophylaxis products that are administered to a military member must be recorded in the individual's permanent health record and/or other paper or DOD-approved electronic ITS.

## **8-5. Information requirements for emergency use authorization products**

Any recipient of an EUA vaccine or chemoprophylaxis product must receive the information (for example, briefing, individual counseling, information statements) required by the FDA-approved EUA. Full compliance with this requirement is critical.

## **8-6. Department of Defense requests for emergency use authorizations**

Requests for possible EUAs for military purposes must be submitted to ASD(HA) for consideration.

## **8-7. Coordination**

The Army, as the Executive Agent for the Immunization Program for Biological Warfare Defense, maintains a program office at the USAMMDA to execute oversight and coordination of the use of EUA products for Force Health Protection.

## **Appendix A References**

### **Section I Required Publications**

There section contains no entries.

### **Section II Related Publications**

A related publication is a source of additional information. The user does not have to read a related publication to understand this regulation.

**AR 11–2**  
Management Control

**AR 25–30**  
The Army Publishing Program

**AR 600–20**  
Army Command Policy

**AFI 48–123**  
Medical Examination and Standards

**COMDTINST M6000.1**  
Medical Manual. (Available at <http://www.uscg.mil/>.)

**DODD 1241.1**  
Reserve Component Medical Care and Incapacitation Pay for Line of Duty Conditions. (Available at <http://www.dtic.mil/whs/directives/>.)

**DODD 1404.10**  
Emergency–Essential (E–E) DOD U.S. Citizen Civilian Employees. (Available at <http://www.dtic.mil/whs/directives/>.)

**DODD 6200.2**  
Use of Investigational New Drugs for Force Health Protection. (Available at <http://www.dtic.mil/whs/directives/>.)

**DODD 6200.3**  
Emergency Health Powers on Military Installations. (Available at <http://www.dtic.mil/whs/directives/>.)

**DODD 6205.3**  
DOD Immunization Program for Biological Warfare Defense. (Available at <http://www.dtic.mil/whs/directives/>.)

**DODI 1400.32**  
DOD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures. (Available at <http://www.dtic.mil/whs/directives/>.)

**DODI 5010.40**  
Manager’s Internal Control (MC) Program Procedures. (Available at <http://www.dtic.mil/whs/directives/>.)

**DODI 6205.2**  
Immunization Requirements. (Available at <http://www.dtic.mil/whs/directives/>.)

**DODI 6205.4**  
Immunization of Other Than U.S. Forces (OTUSF) for Biological Warfare Defense. (Available at <http://www.dtic.mil/whs/directives/>.)

**Executive Order 13139**  
Improving Health Protection of Military Personnel Participating in Particular Military Operations. (Available at <http://www.archives.gov/federal-register/executive-orders/disposition.html>.)

**NATO STANAG 2037**

Vaccination of NATO Forces, 4 February 2005. (Visit NATO Online at <http://www.nato.int/docu/standard.htm>.)

**NATO STANAG 2491**

NBC/MED Policy for the Immunization of NATO Personnel Against Biological Warfare Agents, 22 May 2003. (Visit NATO Online at <http://www.nato.int/docu/standard.htm>.)

**NATO STANAG 3474**

Temporary Flying Restrictions Due to Exogenous Factors Affecting Aircrew Efficiency, 18 October 1996. (Visit NATO Online at <http://www.nato.int/docu/standard.htm>.)

**10 USC 1107**

Notice of use of an investigational new drug or a drug unapproved for its applied use. (Available at <http://uscode.house.gov/>.)

**15 USC 1471**

Definitions. (Available at <http://uscode.house.gov/>.)

**15 USC 1472**

Special packaging standards. (Available at <http://uscode.house.gov/>.)

**15 USC 1473**

Conventional packages, marketing. (Available at <http://uscode.house.gov/>.)

**15 USC 1474**

Special packaging of household substances for protection of children. (Available at <http://uscode.house.gov/>.)

**15 USC 1475**

Repealed. Pub. L. 97-35, title XII, Sec. 1205(c), Aug. 13, 1981, 95 Stat. 716. (Available at <http://uscode.house.gov/>.)

**15 USC 1476**

Preemption of Federal standards. (Available at <http://uscode.house.gov/>.)

**21 USC 360**

Registration of producers of drugs or devices. (Available at <http://uscode.house.gov/>.)

**21 CFR 312**

Investigational New Drug Application. (Available at <http://www.gpoaccess.gov/cfr/index.html>.)

**29 CFR 1605**

Guidelines on Discrimination Because of Religion. (Available at <http://www.gpoaccess.gov/cfr/index.html>.)

**29 CFR 1910.1030**

Bloodborne pathogens. (Available at <http://www.gpoaccess.gov/cfr/index.html>.)

**Section FORM****Prescribed Forms**

This section contains no entries.

**Section IV****Referenced Forms**

Except where otherwise indicated below, the following forms are available as follows: DA Forms are available on the Army Electronic Library (AEL) CD-ROM (EM 0001) and the APD Web site (<http://www.apd.army.mil>); DD Forms are available from the OSD Web site (<http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm>); Standard Forms (SF) and Optional Forms (OF) are available from the GSA Web site (<http://www.gsa.gov>).

**DA Form 11-2-R**

Management Control Evaluation Certification Statement

**DD Form 2365**

DOD Civilian Employee Overseas Emergency–Essential Position Agreement

**DD Form 2766**

Adult Preventive and Chronic Care Flowsheet (Available through normal forms supply channel.)

**DD Form 2766C**

Adult Preventive and Chronic Care Flowsheet (Continuation Sheet) (Available through normal forms supply channel.)

**FDA Form 3500**

MedWatch: The FDA Safety Information and Adverse Event Reporting System (Available at <http://www.fda.gov/medwatch/index.html>.)

**Form VAERS-1**

Vaccine Adverse Event Reporting System (Available at <http://www.vaers.hhs.gov>.)

**PHS Form 731**

International Certificate of Vaccination (Available through normal forms supply channel.) (Marine Corps and Navy—S/N 0108–LF–400–0706. Available from the Navy Supply System and may be requisitioned per NAVSUP P–2002D.)

**SF 600**

Medical Record – Chronological Record of Medical Care

**SF 601**

Health Record – Immunization Record

**Appendix B  
Standards for Military Immunization****B–1. Standard #1 immunization availability**

- a.* Immunizations are available with minimum disruption of deployment or training schedules.
- b.* Immunizations are available at convenient times, without unnecessary barriers. Immunization services are available on a walk–in basis, as staffing permits. Physical examinations and temperature measurements before immunization are not routinely required if they would delay or impede the timely receipt of immunizations. As clinically appropriate, beneficiaries receive simultaneously the vaccine doses required.
- c.* Immunizations services are responsive to the needs of beneficiaries.
- d.* Providers incorporate immunization screening and services as a routine part of clinical care for all beneficiaries. Standing orders with quality assurance procedures are implemented, rather than depending on individual written orders or referral from a primary care provider.

**B–2. Standard #2 information and education before immunization**

- a.* Current versions of DOD information brochures or CDC VISs are provided before immunization and conspicuously available in waiting areas of immunization clinics.
- b.* Immunization personnel know how to readily obtain answers to patients' immunization questions. Personnel are available to accurately address questions and concerns posed by the vaccines.
- c.* Before immunization, the vaccinee (individually or collectively) is given information about benefits and risks associated with immunization. For complicated topics (for example, anthrax, smallpox), detailed educational programs and brochures are provided. This information is culturally appropriate and at an appropriate level.

**B–3. Standard #3 vaccine storage and handling**

- a.* Staff members adhere to cold–chain management principles, including both transportation and storage. A temperature monitoring process is used.
- b.* Vaccine inventories exceeding \$25,000 are connected to temperature recording devices and alarm systems.

**B–4. Standard #4 indications and contraindications to immunization**

- a.* Each patient is asked about allergies, health status, and previous adverse events before immunization. Each patient is provided an opportunity to ask questions about potential contraindications. Patients are referred for appropriate medical evaluation as needed.
- b.* During screening, the patient receives a comprehensive screening for all vaccine needs.

c. Immunization personnel understand the patient's personal situation before immunization. If a contraindication to immunization exists, this information is documented in the health record and ITS. Women are screened with regard to pregnancy (see para 2–5, above).

#### **B–5. Standard #5 immunization recordkeeping**

a. Immunizations are recorded accurately in a DOD–approved electronic tracking system according to Service–specific policy. Immunization records are updated at the time of immunization.

b. The immunization clinic or military unit has 1 or more mechanisms for notifying patients when the next dose of an immunization series is needed (that is, a reminder system).

c. The immunization clinic or military unit has 1 or more mechanisms for notifying patients when they are overdue for immunization (that is, a recall system).

d. Electronic ITS are the preferred immunization record for DOD and USCG personnel. All Services record military immunization data into an electronic database that communicates with a centralized DOD registry. Reminder and recall systems may be automated or manual and may include mailed, e–mailed, or telephone messages.

#### **B–6. Standard #6 training**

a. Persons who administer vaccines must be appropriately trained.

b. Medical personnel administer vaccines after training to a standard acceptable to the MTF commander, command surgeon, or other appropriate medical authority. Training will include vaccine storage and handling, vaccine characteristics, patient interviewing techniques, distinguishing valid and invalid contraindications, injection technique, documentation, managing and reporting of adverse events, and anaphylaxis.

c. Persons who administer vaccines complete at least 8 hours of annual continuing education and training on current immunization recommendations, schedules, and techniques. Training resources include resident courses, the self–paced project immune readiness (<http://www.vhcinfo.org>), and video training from CDC.

d. Persons who administer vaccines have ready access to information resources regarding current recommendations for childhood, general adult, travel, and military–specific immunizations.

#### **B–7. Standard #7 adverse events after immunization**

a. Epinephrine (such as auto–injectable epinephrine), properly stored, is readily available along with other supplies determined locally.

b. Staff members have ready access to reporting options for the VAERS.

c. A quality improvement process assures adverse events are reported to VAERS promptly.

d. Persons who administer vaccines are close to a telephone or radio, so emergency medical personnel can be summoned. Medical providers document adverse events in the health record at the time of the event or as soon as possible thereafter.

#### **B–8. Standard #8 vaccine advocacy to protect the military family**

a. The medical facility knows the extent of influenza and pneumococcal immunization coverage among its high–risk patients and has a plan to optimize that level.

b. The medical facility implements a plan to optimize immunization rates among cardiac, pulmonary, diabetic, asplenic, and other patient groups at elevated risk of complications from vaccine–preventable infectious diseases.

c. The medical facility conducts a quality improvement program to optimize its performance in immunizing children, adolescents, and adults against the preventable infections that most threaten them.

d. Commanders use immunization databases to identify and resolve the vulnerabilities of their units.

e. Commanders have plans to help their beneficiaries optimize their personal protection against preventable infectious diseases and meet national goals for optimal delivery of influenza and pneumococcal vaccines. All health care providers (not just those in immunization clinics) routinely determine the immunization status of their patients, offer vaccines to those for whom they are indicated, and maintain complete immunization records

## **Appendix C Medical and Administrative Exemption Codes**

### **C–1. Medical exemption codes**

Medical exemption codes appear in table C–1, below.

**Table C-1**  
**Medical exemption codes**

Code	Meaning	Explanation of example	Duration
MA	Medical assumed	Prior immunization reasonably inferred from individual's past experiences (for example, basic military training), but documentation missing. Code used to avoid superfluous immunization. Code can be reversed upon further review.	Indefinite
MD	Medical, declined	Declination of optional vaccines (not applicable to many military vaccinations), religious waivers.	Indefinite
MI	Medical, immune	Evidence of immunity (for example, by serologic antibody test, "take" after smallpox vaccination); documented previous infection (for example, chickenpox infection); natural infection presumed (for example, measles, if born before 1957).	Indefinite
MP	Medical, permanent	HIV infection, prolonged or permanent immune suppression, other contraindication determined by physician. Can be reversed if the condition changes. For tuberculosis, positive tuberculosis test.	Indefinite
MR	Medical, reactive	Permanent restriction from receiving additional doses of a specific vaccine. Use only after severe reaction after vaccination (for example, anaphylaxis). Report such reactions to VAERS. Code can be reversed if an alternate form of prophylaxis is available. Do not code mild, transient reactions as MR. code events referred for medical consultation as MT.	Indefinite
MS	Medical, supply	Exempt due to lack of vaccine supply.	Up to 90 days
MT	Medical, temporary	Pregnancy, hospitalization, events referred for medical consultation, temporary immune suppression, convalescent leave, pending medical evaluation board, any temporary contraindication to immunization.	Up to 365 days

**C-2. Administrative codes**

Administrative exemption codes appear in table C-2, below.

**Table C-2**  
**Administrative exemption codes**

Code	Meaning	Explanation of example	Duration
AD	Administrative, deceased	Individual is deceased.	Indefinite
AL	Administrative, emergency leave	Individual is on emergency leave.	Up to 30 days
AM	Administrative, missing	Missing in action, prisoner of war.	Indefinite
AP	Administrative, PCS	Permanent change of station.	Up to 90 days
AR	Administrative, refusal	Personnel involved in actions under the Uniformed Code of Military Justice, religious waiver.	Until resolution
AS	Administrative, separation	Pending discharge, separation (typically within 60 days), retirement (typically within 180 days).	
AT	Administrative, temporary	Absent without leave, legal action pending (other than code AR).	Up to 90 days
NR	Not required	Individuals who received immunization while eligible, subsequently changed occupational category and now serve as civilian employees or contract workers not otherwise required to be immunized.	Indefinite

## Appendix D Immunizations for Military Personnel

### D-1. Text citations

Paragraphs 2-6b, 3-1g, 3-1h, and 3-1i provide additional information on immunizations for military personnel.

### D-2. Table D-1

Table D-2, below, provides a listing of required immunizations for military personnel.

**Table D-1**  
**Immunizations for military personnel**

Immunizing agent	Army	Navy	Air Force	Marine Corps	Coast Guard
Anthrax	S	S	S	S	S
Hepatitis A	All	All	All	All	All
Hepatitis B	Acc,Occ,S,T	Acc,Occ,S,T	Acc,Occ,S,T	Acc,Occ,S,T	All
Influenza	All	All	All	All	All
Japanese encephalitis	S,T	S,T	S,T	S,T	S,T
Measles	All	All	All	All	All



**Table D-1  
Immunizations for military personnel—Continued**

Immunizing agent	Army	Navy	Air Force	Marine Corps	Coast Guard
Meningococcal	Acc,S,T	Acc,S,T	Acc,S,T	Acc,S,T	Acc,S,T
Mumps	All	All	All	All	All
Poliovirus	All	All	All	All	All
Rabies	Occ,S	Occ,S	Occ,S	Occ,S	Occ,S
Rubella	All	All	All	All	All
Smallpox (vaccinia)	S	S	S	S	S
Tetanus–diphtheria (preferably with pertussis vaccine)	All	All	All	All	All
Typhoid	S,T	S,T	S,T	S,T	S,T
Varicella	Acc,Occ,S	Acc,Occ,S	Acc,Occ,S	Acc,Occ,S	Acc,Occ,S
Yellow Fever	S,T	S,T	S,T	All	Acc,S,T

Notes:

<sup>1</sup> See text for discussion of immunizations for civilian personnel and contracted workers.

<sup>2</sup> Acc—Accessions in initial entry training, academies, and other officer training. (See text for discussion of two clusters of immunization.)

<sup>3</sup> AD—Active duty personnel.

<sup>4</sup> Occ—High-risk occupational groups.

<sup>5</sup> S—Specified by DOD, USCG, Service or combatant command policy for identified subpopulations (for example, early deployers, special operations, alert forces). (See text for expanded discussion.)

<sup>6</sup> T—Traveling or deploying to high-risk areas based on threat assessment or host country requirement.

## **Appendix E Management Control Evaluation Checklist**

### **E-1. Function**

The function covered by this checklist is immunization and chemoprophylaxis.

### **E-2. Purpose**

The purpose of this checklist is to assist in evaluating key management controls and is not intended to address all controls. The evaluation is focused at the clinic level, regardless of Service, to include both fixed facilities (MTFs, TDA units) and TOE field units. The checklist serves as a clinical quality improvement tool and is described at <http://www.vaccines.mil/cqip>.

### **E-3. Instructions**

Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, interviewing, sampling, or simulation). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. These key management controls must be formally evaluated at least once every 3 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-5 (Management Control Evaluation Certification Statement).

### **E-4. Test questions**

Test questions are available directly via a link at the Web site address in paragraph E-2, above.

### **E-5. Supersession**

This is a newly developed checklist.

### **E-6. Comments**

Help make this a better tool for evaluating the Military Immunization Program. Submit comments to HQDA (DASG-HCA), 5113 Leesburg Pike, Falls Church, VA 22041-3158.

## **Glossary**

### **Section I Abbreviations**

#### **ACIP**

Advisory Committee on Immunization Practices

#### **AFI**

Air Force Instruction

#### **AFJI**

Air Force Joint Instruction

#### **ASD(HA)**

Assistant Secretary of Defense (Health Affairs)

#### **CBRN**

chemical, biological, radiological, or nuclear

#### **CDC**

Centers for Disease Control and Prevention

#### **CFR**

Code of Federal Regulations

#### **CG-11**

Coast Guard, Director of Health and Safety

#### **COMDTINST**

Commandant Instructions

#### **DCJI**

disposable-cartridge jet injectors

#### **DD**

Department of Defense Form

#### **DHHS**

Department of Health and Human Services

#### **DOD**

Department of Defense

#### **DODD**

Department of Defense Directive

#### **DODI**

Department of Defense Instruction

#### **EUA**

emergency use authorization

#### **FDA**

Food and Drug Administration

#### **FORSCOM**

U.S. Army Forces Command

#### **G6PD**

glucose-6-phosphate dehydrogenase

**Hib**

Haemophilus influenzae type b

**HQ**

Headquarters

**HQDA**

Headquarters, Department of the Army

**IND**

investigational new drug

**IPV**

inactivated poliovirus vaccine

**ITS**

immunization tracking systems

**JEV**

Japanese–encephalitis vaccine

**MAJCOM**

major command

**MMR**

measles, mumps, rubella

**MTF**

military treatment facility

**MUNJI**

multi–use nozzle jet injectors

**NCVIA**

National Childhood Vaccine Injury Act

**ND**

new drug

**NVIC**

National Vaccine Injury Compensation

**OTUSF**

other than U.S. Forces

**PHS**

Public Health Service

**RC**

Reserve Component

**ROTC**

Reserve Officer's Training Corps

**SF**

Standard Form

**SSN**

social security number

**STANAG**

(International Military) Standardization Agreement

**Td**

Tetanus–diphtheria

**Tdap**

Tetanus–diphtheria and acellular pertussis (vaccine)

**USAMMDA**

U.S. Army Medical Materiel Development Activity

**USC**

United States Code

**USCG**

United States Coast Guard

**VAERS**

Vaccine Adverse Events Reporting System

**VHC**

Vaccine Healthcare Centers

**VIS**

vaccine information statements

**VISI**

Vaccine Identification Standards Initiative

**WHO**

World Health Organization

**Section II****Terms**

This section contains no entries.

**Section III****Special Abbreviations and Terms**

This section contains no entries.

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