

NOVEL H1N1 INFLUENZA
GUIDANCE FOR CONNECTICUT SCHOOL NURSES
August 20, 2009

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INTRODUCTION

I. Purpose

The purpose of this guidance is to review the current mitigation strategies and identify ways that school nurses can assist with the management of the H1N1 influenza illness in the school setting. Although each school and school nurse has different resources available, it is clear that **the school nurse is an essential element** in the planning and delivery of any school-based interventions. Since most of the disease identified, to date has been in the population under 18 years, schools have been identified as the epicenter of this current pandemic. Therefore, many mitigation interventions are focused on schools and school-aged children.

As school nurses engage in assisting with the planning and delivery of school-based interventions, it is important to identify the resources within their school and school systems, as well as collaborate and coordinate with the local health authority in their school community. It should also be made clear that this is a **guidance** document and is not meant to prescribe or require the nurse to perform in any way. These guidelines present opportunities for the nurse to use the skills they have in assessing illness in children, and given the unique position of trust and respect they have within the school community, to contribute to the management of an outbreak of H1N1 flu.

This guidance is based on the most current information (August 2009) and is an evolving situation therefore, the best advice is to keep informed and updated by following the Connecticut H1N1 Web site at <http://www.ct.gov/ctfluwatch/site/default.asp> and Centers for Disease Control and Prevention (CDC) Web site at <http://www.cdc.gov/H1N1flu/>.

II. Background of H1N1 influenza virus

On April 24, 2009 the Centers for Disease Control and Prevention¹ reported on two cases of Influenza of Swine Origin, in children, in Southern California. The identification of those two cases began the current epidemic of this Novel influenza virus in the United States. Shortly after that, on April 28, 2009, Connecticut identified its first probable (later confirmed) case. In June of 2009, the World Health Organization (WHO) declared an H1N1 Pandemic phase 6. The pandemic phase 6 is characterized by community level outbreaks in at least one other country in a different WHO region. Designation of this phase indicates that a global pandemic is under way. In addition, Phase 6 includes the criteria defined in Phase 5. Phase 5 is characterized by human-to-human spread of the virus into at least two countries in one WHO region Designation of this phase will indicate that a global pandemic is under way. For a description of WHO Pandemic phases, see Appendices 1 and 2.

Novel H1N1 is a new influenza virus causing illness in people. This virus was originally referred to as “swine flu” because laboratory testing showed that many of the genes in this new virus were very similar to influenza viruses that normally occur in pigs in North America. Further study has shown that this new virus is very different from what normally circulates in North American pigs. It has two genes from flu viruses that normally circulate in pigs in Europe and

Asia and avian genes and human genes. Scientists call this a "quadruple reassortment " virus. The symptoms of novel H1N1 flu virus in people are similar to the symptoms of seasonal flu and include fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills and fatigue. A significant number of people who have been infected with this virus also have reported diarrhea and vomiting. Also, like seasonal flu, severe illness and death has occurred as a result of infection associated with this virus.

Spread of novel H1N1 virus is thought to be happening in the same way that seasonal flu spreads. Flu viruses are spread mainly from person to person through coughing or sneezing by people with influenza. Sometimes people may become infected by touching something with flu viruses on it and then touching their mouth or nose.

At the current time, CDC believes that this virus has the same properties in terms of droplet spread as seasonal flu viruses. With seasonal flu, studies have shown that people may be contagious from one day before they develop symptoms to up to 7 days after they get sick. Children, especially younger children, might potentially be contagious for longer periods. CDC is studying the virus and its capabilities to try to learn more and will provide more information as it becomes available.

III. Local Resources

While resources within local communities vary among towns and schools, they should include:

- School Superintendents
- School Nurse Supervisors
- School Based Health Centers:
http://www.ct.gov/dph/cwp/view.asp?a=3138&q=387698&dphNav_GID=1601
- Principals
- Local pediatric health care providers
- Local Health Authorities https://www.han.ct.gov/local_health/localmap.asp
- Local Community Health Centers <http://www.ct.gov/dph/cwp/view.asp?a=3138&q=404886>
- Connecticut Association of School Based Health Centers, Inc (SBHC).
<http://www.ctschoolhealth.org/>
- CT Department of Education Child Nutrition and Health Unit

IV. Glossary of Terms

- **Community Mitigation:** Efforts initiated to lessen an epidemic by decreasing spread of illness agent.
- **Cough etiquette:** Using source control measures to prevent patients with respiratory infections from transmitting their infection to others; for example, cover their mouth and nose with a tissue and dispose of used tissue in waste containers; use of a mask if coughing (when a mask can be tolerated).
- **Epidemic:** Occurrence of more cases of disease than expected in a particular area or among a specific group of people over a period of time. Often synonymous with outbreak; however, an outbreak is usually of a smaller scale.

- **ILI:** Influenza Like Illness: Illness with symptoms of fever $>100^{\circ}\text{F}$ **AND** sore throat or cough
- **Mitigation:** To moderate (a quality or condition) in force or intensity; alleviate. To relieve or help become milder.
- **Pandemic:** Epidemic occurring in a very wide area (several countries or continents) and usually affecting a large portion of the population.
- **Social Distancing:** Increasing the physical space between individuals or infected populations with the aim of delaying spread of illness.

Community Mitigation (Non-pharmaceutical Interventions)

Community strategies that do not involve vaccines or medications (also called non-pharmaceutical interventions) may serve as a first line of defense to help delay and lessen the spread and severity of influenza. Each intervention relates to the goal of decreasing contact between people during the epidemic or decreasing potential infectious agents from spreading. CDC has published guidance on some of these strategies, H1N1 Flu (Swine Flu): Resources for Child Care Programs, Schools, Colleges, and Universities at: <http://www.cdc.gov/h1n1flu/schools/>.

School nurses serve an important role in the implementation of these strategies. As the health consultant for their schools, school nurses serve in an advisory role in planning for any of the interventions described. As mentioned in the introduction, coordination and collaboration with key players, such as school administrators, school medical advisors and local health authorities are essential to successful interventions.

V. Social Distancing

Mitigation guidelines issued by the CDC (February 2007) include social distancing strategies to reduce contact between people. The school nurse should serve in an advisory capacity for planning for school closures and social distancing. These social distancing strategies may include:

- Closing schools – the decision to close a school for health reasons is generally made by local school authorities in collaboration and coordination with the local health authority.
- Canceling public gatherings;
- Planning for liberal work leave policies;
- Telecommuting work strategies;
- Voluntary isolation of cases; and
- Voluntary quarantine of household contacts.

The above interventions can be used proactively or reactively. Implementation of any of the social distancing strategies alone may be of limited use, especially closing schools and allowing children to congregate in other settings.

VI. Closing Schools

Decisions about school closure are at the discretion of local authorities based on local considerations, including public concern and the impact of school absenteeism and staffing shortages. School administrators, in consultation with their school health staff, should communicate regularly with local public health officials to obtain guidance about reporting of influenza-like illnesses in schools and making decisions about school closures.

The CDC and U.S. Department of Education initiated a voluntary reporting system for monitoring the number of schools that are closed for H1N1 related issues. While reporting is voluntary, it is recommended that schools report closures so that we may monitor the impact of

H1N1 illnesses. For more information, please see School Dismissal Monitoring System: http://www.cdc.gov/h1n1flu/schools/d dismissal_form/.

VII. Monitoring Illness in Schools

Early identification of influenza outbreaks can be assessed by school nurses to limit the spread of the communicable disease. For H1N1, this would include the identification of Influenza-Like Illness (ILI) in students and staff. ILI is defined as fever of >100°F AND sore throat or cough. School nurses can:

- Conduct risk assessments, including illnesses within families of symptomatic students.
- Support school administration by collecting and reporting the number of children (and staff) who report to the health office, including the reason for the visit.
- Support existing or create new data collection tools that collect school absence information or visits to the health room. This information is especially helpful when attempting to identify if there is an outbreak occurring in the school or in making decisions on closing schools due to severe illness in the school. Coordinate with local health authorities is essential to avoid duplication of efforts. Appendix 4 includes a sample of a data collection tool which was developed and is used by the school nurses in the Milford School System.

VIII. At-Risk Students

School nurses should identify students (and staff) who have medical conditions that put them at risk for complications of influenza. When influenza illness is identified in your school, these higher-risk groups should be notified. This notification allows the parents of these students or the staff impacted to contact their own health care provider for advice on any measures they should take to minimize illness or treat symptoms early, if they get sick.

For seasonal influenza, the following groups are known to be high- risk for complications or known to be at-risk for spreading illness to those that might experience complications:

- Pregnant women
- People 65 years of age and older
- People of any age with certain chronic medical conditions such as diabetes, heart disease or pulmonary disease, including asthma
- People who live in nursing homes or other long-term care facilities
- People who live with or care for those at high-risk for complications from flu, including: health care workers; household contacts of persons at high-risk for complications from the flu; and household contacts and out of home caregivers of children less than 6 months of age (these children are too young to be vaccinated).

Note: These populations are not necessarily most likely to get ill with H1N1 but those more likely to experience more severe disease.

IX. Exclusion Policies

School nurses should support the adoption of and assist in the implementing of measures that keep sick students and staff at home. Such measures might include:

- Sending a welcome back to school letter with the school policies on illnesses and reminders about when to keep your child home. Urge parents to think about who will care for their child, should the child have to be out of school for any time period.
- Drafting and implementing policies on care and exclusion of sick children and staff.
- Disseminating school policy to parents and local health care providers.
- Suggesting ways to talk to children about H1N1.

Although the school nurse does not have direct care responsibilities for staff, the school nurse is often asked to provide support for illness in school staff. The staff should be assessed and excluded from the school setting using the same criteria as students. Additionally, the school nurse may also have information about the health status of staff which may be helpful in determining which staff members may be at higher risk for H1N1.

X. Education

School nurses are the medical professionals in school environments and can offer to educate students, staff and parents about the latest information about H1N1, how to maintain health, as well as mitigating interventions to decrease the spread of infectious agents. This can be accomplished through: classroom presentations; fact sheets; newsletters; school Web Sites; and other venues.

Many H1N1 education materials are available from other sources to educate parents, students and staff including:

- “Taking Care of a sick person at home” at http://www.cdc.gov/h1n1flu/guidance_homecare.htm
- National Association of School Nurses at www.nasn.org
- “What to do if you get flu like symptoms” at <http://www.cdc.gov/h1n1flu/sick.htm>
- “Novel H1N1 and You” at <http://www.cdc.gov/h1n1flu/qa.htm>
- Flyers and other print material at <http://www.cdc.gov/h1n1flu/flyers.htm>
- “Clean Hands save lives” at <http://www.cdc.gov/h1n1flu/pdf/handwashing.pdf>
- “Don’t share keep germs from spreading” at http://www.ct.gov/dph/lib/dph/communications/cerc/dontshare_english.pdf
- “Cover your cough” at http://www.cdc.gov/flu/protect/pdf/covercough_school8-5x11.pdf

XI. Mitigating Interventions to Decrease the Spread of Infectious Agents

Mitigating, or slowing the spread of illness, is desired in any infectious disease outbreak. There are some specific mitigation measures that can be employed to help accomplish this sometimes daunting task. These measures might include:

- Covering your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
- Washing your hands often with soap and water, especially after you cough or sneeze. Hand-washing is the most effective way to prevent the spread of illnesses. If soap and water is not readily available for frequent hand washing, use alcohol-based, or non-alcohol based hand sanitizers. Alcohol based and non alcohol based hand cleaners are both effective in decreasing the spread of infectious agents.
- Avoid touching your eyes, nose or mouth. Germs spread this way.
- Try to avoid close contact with sick people.
- Keeping sick children and staff home if they are sick. CDC recommends that people with Influenza-Like Illness remain at home until at least 24 hours after they are free of fever (100° F [37.8°C]), or signs of a fever without the use of fever-reducing medications. CDC reports that people generally are febrile for 3-5 days. This is to keep from infecting others and spreading the virus further. As guidance on the length of time to keep sick children out of school may change, it is important to continue to monitor the CDC web site at www.cdc.gov/h1n1flu.

XII. Isolation

Isolate students, faculty and staff who appear to have an Influenza-Like Illness at arrival to school or become ill during the day promptly in a room separate from other students and staff. Those ill students and staff should be sent home as outlined in the school district policy.

XIII. Cleaning and Disinfecting Surfaces

Studies have shown that influenza virus can survive on environmental surfaces and can infect a person for up to 2-8 hours after being deposited on the surface. By the time students and staff come to the school in the morning, any influenza virus on surfaces from the day before would no longer be capable of infecting a person touching those surfaces. In light of this fact, there is no evidence to close a school for the purpose of cleaning when influenza cases are detected among staff and students. Instead, schools should continue to clean and disinfect the school buildings routinely according to the regularly followed schedule. Furthermore, routinely used disinfectants are effective in inactivating the virus.

For more information on cleaning of schools, visit the Connecticut Flu Watch website at: http://www.ct.gov/ctfluwatch/lib/ctfluwatch/h1n1/72209/cleaning_schools.pdf.

Community Mitigation: Vaccination in a School Setting

During the spring of 2009, the largest number of cases of H1N1 was in school- aged children and keeping schools open presented a challenge for educators and public health personnel. At that time, no vaccine was available to prevent the disease. For the fall of 2009, the potential for a licensed vaccine to prevent H1N1 influenza exists. While influenza vaccines are generally not 100% effective, they are the best tool available to prevent influenza.

Historically, school aged children received influenza vaccinations at their health care provider offices. In 2008, the Advisory Committee on Immunization Practices (ACIP) expanded the influenza vaccination recommendation to include all children aged 6 months to 18 years. Several reasons make this recommendation cost effective. First, school-aged children have the highest infection rate for seasonal influenza.⁴ Second, vaccinating school children would benefit children and reduce disease burden among their contacts (including adults).⁵ Among the many challenges presented by this recommendation the biggest is, “How to immunize so many people, every year, in such a short time period”? Children spend a good deal of their day in schools. Therefore, schools are a logical setting for vaccination clinics for children. Since 2008, many models for delivery of vaccine to the school-aged children have been used, including:

- Community Based clinics- “family” mass vaccination clinics where all family members can be vaccinated.
- Private Providers- individual appointments or private practice “clinics” during or after practice office hours.
- School-located vaccination clinics – Vaccination clinics held in school buildings that can be one of several models:
 - Organized and staffed by school staff, including school nurses.
 - Organized and staffed by local public health, including public health nurses.
 - Organized and staffed by private health care agencies, including home care nurses, and
 - Organized and staffed by community agencies through School Based Health Centers.
 - Any combination of the above organizations working collaboratively – for example school staff and local public health staff working together to organize and staff a school located clinic.

Children spend a good deal of their day in schools. There are several models, as identified above, for providing vaccinations within a school setting. Each community has different resources which may include school nurses; school-based health center staff; visiting nurse agency; private vaccinating agency; local health authority; public health nurses; medical reserve corps; and public health emergency response volunteers.

For H1N1, the state plan for vaccinating children in grades K-12 centers around the use of entities called Mass Vaccination Areas (MVA). To identify who are the contacts for the MVA in your jurisdiction, contact your local health department. Your local health department can be found on the Department of Public Health website www.ct.gov/dph .

Background

Children spend a good deal of their day in schools. Therefore, schools are a logical setting for vaccination clinics for children. This may make the act of receiving a vaccine more tolerable to a child knowing his/her classmates are receiving the same vaccine. Historically, immunization campaigns have been used in school settings to initiate a new vaccine, like polio, rubella and Hepatitis B. Vaccinations have also been used to successfully interrupt an outbreak, like varicella, measles and meningitis. Success is measured by achieving high vaccination rates, interrupting outbreaks and showing preventive benefits.

What resources are available to provide vaccinations in a school setting? Once again this list includes potential resources. Not all resources identified are available within all school(s) or districts.

- School Nurses
- School-based health center staff
- Visiting Nurse Agency (VNA)
- Private vaccinating agency (Maxim)
- Local health department
 - Public Health Nurses
 - Medical Reserve Corps
 - Public Health Emergency Response Volunteers

XIV. Organizing a School Located Vaccination Clinic

School nurses are essential when determining the need and desire to provide a H1N1 influenza vaccination clinic in the school setting and thus are integral members of the planning team. School nurses know their students; are trusted and credible persons; students and parents are used to receiving “medical” advice and education from them; and school nurses are used to giving and supporting preventive health care measures in schools, including immunization administration. Vaccination clinics in a school setting must be in collaboration with local health authorities. School nurses are a member of the planning team and are not expected to single handedly orchestrate a vaccination clinic.

The information below comes from public health experience in school-located immunization clinics. There are several models for providing school located vaccination clinics. We recognize that each community has different resources. If another agency is the driving force for this clinic, these steps will also need to be followed, with assurance that the school nurse and school administrative staff are involved in the planning from the beginning. Once again these should be collaborative efforts with local health departments.

The National Association of City and County Health Officials (NACCHO) sponsored a school located influenza immunization webinar on August 11, 2009. For the archive of this webinar, please go to: <https://cc.readytalk.com/cc/playback/Playback.do?id=epuhcg>.

Gaining support and permission from the district’s superintendent and principal must be achieved in order to move forward with any planning. They ultimately have the responsibility for schools and can lend credibility and support to the vaccination effort. Families often trust and rely on them for advice, including if they should vaccinate their children. School Administrators

can be given information to encourage participation by emphasizing the benefits of school clinics such as reduced school absenteeism among students and staff.

The following 12 steps should be considered when organizing and administering a school-located vaccination clinic. While this appears to be a cumbersome undertaking, remember that use of collaborative efforts are best to achieve a successful school-located influenza immunization campaign.

Step 1. Identify a Planning Team - Once the decision is made to house a vaccination clinic within a school setting, a planning team should be established in order to effectively and efficiently coordinate the effort.

Members of the planning team should include:

- School Nurse;
- School Medical Advisor;
- Superintendent or designee;
- Principal;
- Community Medical Partners;
- School-based health centers;
- Local health departments;
- Visiting Nurse agencies;
- Pediatricians; and
- Family Practices.

Step 2. Choosing the appropriate school(s) to use in a school-sponsored vaccination program-

- Logistic factors include: Geographic location (proximity to priority populations), type of school (depending upon target population this may be a factor), and room location (ease of access, adjacent to adequate parking, security for people entering and leaving the location).

Step 3. Clinic hours-

- The decision to hold the clinic during the school day or after school is a major planning consideration. If held during the school day, disruption to the educational environment will need to be taken into account. If held after school, diminished vaccination rates could result as the “convenience factor” of holding the vaccination clinic in school is weighed against other factors of family life.

A table of associated Pro’s and Con’s with conducting school-located immunization clinics during or after school can be found on the next page.

Pro’s and Con’s for holding a clinic during school

Pro’s	Con’s
<ul style="list-style-type: none"> • Students are a “captive audience” during the day, providing a greater potential for immunizing a high percentage of students. 	<ul style="list-style-type: none"> • Students afraid to get a “shot” at school which could lead to a stigma associated with the educational setting.
<ul style="list-style-type: none"> • Parents won’t have to miss work to get children vaccinated. 	<ul style="list-style-type: none"> • Logistical concerns before clinic day, like rearranging rooms to facilitate vaccination process, obtaining permission forms, etc.
<ul style="list-style-type: none"> • No overtime for school nurses and it is a familiar work setting. 	<ul style="list-style-type: none"> • Vaccination process will result in time away from the educational instruction and programs.

Pro’s and Con’s for holding clinic after school

Pro’s	Con’s
<ul style="list-style-type: none"> • Possibility of having parents present to assist with their child’s vaccination. 	<ul style="list-style-type: none"> • Parents need to return to school/miss work.
<ul style="list-style-type: none"> • Decreased planning time prior to clinics as permission can be obtained at time of clinics. 	<ul style="list-style-type: none"> • Overtime expense for school staff (school nurses, clerical assistance, custodians) could possibly creates funding issues.
<ul style="list-style-type: none"> • Minimal disruption to learning environment. 	
<ul style="list-style-type: none"> • Parent can bring multiple children to one location. 	
<ul style="list-style-type: none"> • Greater room availability after school hours with minimal disruption to learning environment. 	

Step 4. Scheduling and Logistical Considerations-

The planning team will need to weigh various logistical considerations prior to operationalizing a vaccination campaign in a school setting. These considerations include:

- Responsibility for filling staffing needs- the responsibility for assuring that adequate staff is available to obtain permission forms, educate parents/students/school staff, orders supplies, arranging for clinic set up and break down needs to be assigned to appropriate agencies and personnel.
- Vaccinators- determining the numbers of vaccinators needed and their makeup is a priority planning issue. Options for obtaining vaccinators include school nurses, public health nurses, or contracting outside health agencies like VNAs.
- Ancillary staff- appropriate staff need to be available to handle permission forms, schedule appointments, assist in clinic set up and break down, and order supplies, as well as custodial staff for building maintenance and security.

- Vaccine-
 - Type of vaccine to be used: injectable or nasally administered vaccine each provides unique logistical concerns. Injectable vaccine issues include process to fill needles, determining appropriate needle size and vaccine storage requirements. Nasally administered vaccine can cause issues, as it is a live virus vaccine, among potentially immune-compromised populations.
 - Who will obtain the vaccine? Once again, if you are coordinating the clinic, check with your local health department for assistance and direction on obtaining vaccine.
- Room setup- arranging work areas to ensure privacy, registration and vaccination.
- Vaccination process- May need to set up clinic twice to administer 2 vaccinations approximately 30 days apart.

Step 5. Liability- Given that current influenza vaccines are covered by an excise tax for the Vaccine Injury Compensation fund, what other liability concerns may exist and who will cover those concerns? Are there needs for Memorandum of Agreements between groups? Appendix 5 provides for an outline of liability protection under The Public Readiness and Emergency Preparedness Act (PREP). This Act covers vaccination with H1N1 influenza vaccine. Legal issues may arise; including but not limited to, liability concerns, and contracting and personnel issues. These should be addressed by local counsel.

Step 6. Clinic setup- The planning team needs to consider who has the responsibility for assuring that all clinic planning is conducted. Considerations include:

- Developing timeline for planning process- based upon when the vaccine would be available, planning teams can develop timelines by working backward from projected delivery dates.
- Identifying the locations and times for clinics and securing the sites- planning team member will need to conduct site visits to determine if locations are viable. Additionally, negotiations with site administrators would need to occur.
- Obtaining parental permission, including education of parent and child, development of procedures to obtain permission and appropriate educational materials prior to vaccination is essential.
- Securing vaccine and supplies- In working with local health departments, planning team members can assist in providing locations for the physical security of these vital assets.

Step 7. Medical Management- Determining the appropriate medical management for a school based vaccination clinic will be a challenging task for the planning team. Issues to consider include:

- Physician order to administer the vaccine- How will the physician's order to vaccinate be accomplished? Will it be a standing order or individually issued?
- Screening- Prior to obtaining permission to vaccinate students, all potential vaccinees will need to be screened for eligibility and potential contraindications for vaccination. Planning teams need to determine how this screening would be accomplished and when.

- Management of Adverse Vaccine events- Developing a process for medical management and reporting of adverse events during and after vaccination would need to be accomplished. This may include cooperation between private providers and school medical personnel.
- Communicating with medical home (primary health care provider) to assure there is a permanent record of the vaccinations- Continuity of medical records for children that are vaccinated would need to be considered. Information gathered during the registration process and use of digital information gathering tools could help to ensure information is shared appropriately.
- Emergency protocol- Procedures for dealing with an emergency during a vaccination clinic would need to be developed and personnel trained on the protocol prior to the vaccination clinic.

Step 8. Funding- A major consideration in any planning activity is the amount of funding that is available for planning and would be needed to operationalize the clinics. Issues to consider include:

- Indirect costs- Costs incurred in planning and implementation process that are not directly associated with vaccine administration. (i.e. supplies, printing or obtaining educational material for parents and students, training of staff).
- Available Funding Sources- Funding may be available to support the planning for H1N1 influenza vaccinations. A good place to start is through your local health department.
- Vaccine Cost- Currently, for H1N1, the vaccine will be “free”. Guidance from the CDC is expected shortly regarding whether there will be an administration fee reimbursement which may assist in the funding decisions that occur locally.

Step 9. Publicity- Once the decision has been made to conduct vaccinations in a school setting, it will be imperative that agencies “get the word out” to the target population. Some strategies for accomplishing this include:

- School, town and health department web site
- Local media (radio, TV, newspapers articles and interviews)
- Flyers and posters sent home to students (work best with younger kids)
- Athletic teams- student athletes often are role models for other students. Engaging the athletes in the campaign could improve your rates of acceptance
- School Nurses

Step 10. Communicate and Collaborate with local health providers- Collaborating with local medical providers will be an essential element to ensure the patient’s safety and health. The planning team should consider the following when engaging this stakeholder group:

- Resource for their patients- medical providers serve as the primary resource for medical information for many patients. Ensuring that providers have information that is consistent with what is distributed through the clinic will ease patient concerns.

- Get information back to the student's medical home (primary health care provider) - sharing information with each patient's primary care provider will be critical to ensuring continuity of care in the long term.
- Follow up with the potential for a second dose if needed- collaborations with providers may allow for smoother second vaccinations, both in terms of consistent information about the need, and additional capacity for vaccinating patients.

Step 11. Documentation and recall- Data gathered to ensure that parental permission is given and appropriate information about the vaccination process shared will be critical to a successful vaccination campaign. Planning teams should consider the following issues:

- Permission forms- Determining how parental permission will be obtained and verified is critical to ensure that patient rights are upheld. Since this vaccination will potentially be given in the absence of the parent, permission to vaccinate may be a key concern for both vaccinators and vaccinees Appendix 5 contains several examples of permission forms and ideas on how to improve return rates of the permission forms.
- Vaccine Information Statements- Information about the vaccine and the vaccination process will need to be shared with parents or guardians prior to vaccination to ensure that they are aware of potential issues and can make informed decisions about vaccinating their children. It is also a requirement that these statements are shared with each patient to inform them about potential adverse events.
- Since, at the current time, there may be a need for two H1N1 vaccinations to protect a person; a system to either recall vaccinees or provide the vaccinee with written documentation of vaccination and information on the need to follow up with a second dose is a necessary planning element.

Step 12. Practice a clinic walk-through and staff training- Once the vaccination clinic site is determined, the planning team should gather the vaccination team to ensure that they are appropriately briefed on procedures and their roles in the process. A walk-through of the vaccination process and training session should be conducted prior to vaccination clinics. Topics to cover include:

- Identifying Vaccination Team Roles- Vaccination team members should be knowledgeable about the overall vaccination process and where they fit in the chain of command. This will give them the ability to resolve issues efficiently.
- Skills practice- Opportunities to practice skills associated with their individual roles should be given to ensure each team member is comfortable with their tasks.
- Protocols- Team members should be briefed on the proper protocols that have been developed to assist in the operation of the vaccination clinic.
- Emergency procedures- Emergency procedures should be gone over in detail prior to each shift in a vaccination clinic. A safety officer should also be present during clinic operating hours to ensure that safety issues are dealt with appropriately.

XV. Resources

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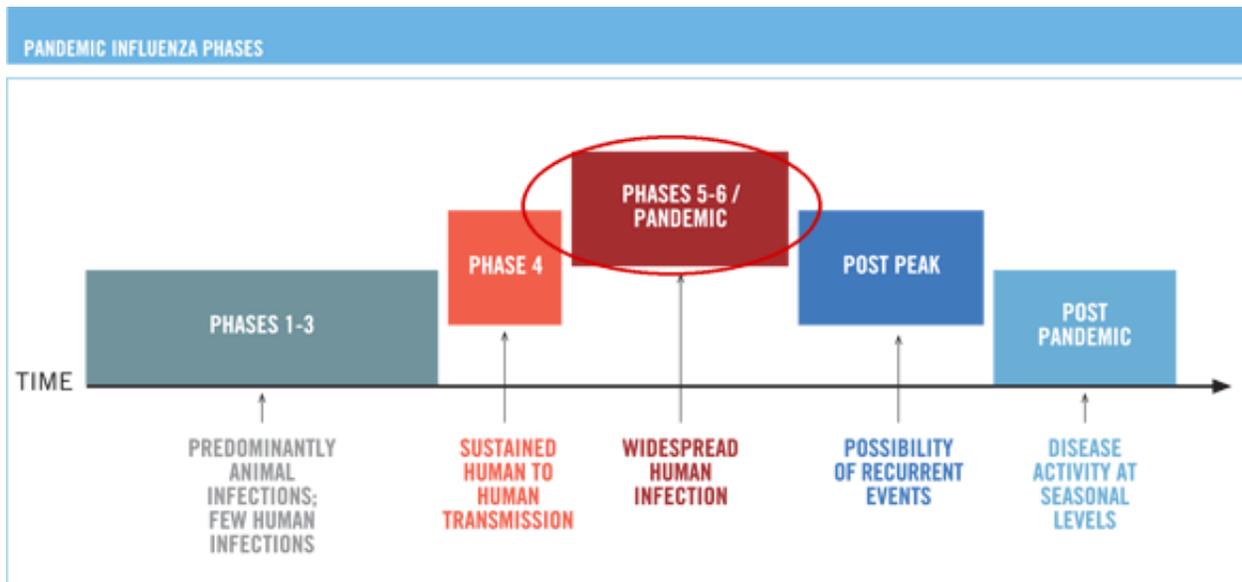
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Appendix 1

WHO Pandemic phases from

http://www.who.int/csr/disease/avian_influenza/phase/en/index.html



Appendix 2

Pandemic Severity Index-Released by the United States Department of Health and Human Services (HHS) on February 1, 2007, the PSI was designed to resemble the Saffir-Simpson Hurricane Scale classification scheme. **A copy of the entire document is available at: http://www.pandemicflu.gov/plan/community/community_mitigation.pdf**

Interventions by Setting	Pandemic Severity Index		
	1	2 and 3	4 and 5
Home			
Voluntary isolation of ill at home (adults and children); combine with use of antiviral treatment as available and indicated	Recommend	Recommend	Recommend
Voluntary quarantine of household members in homes with ill persons (adults and children); consider combining with antiviral prophylaxis if effective, feasible, and quantities sufficient	Generally not recommended	Consider	Recommend
School			
Child social distancing dismissal of students from schools and school-based activities, and closure of child care programs	Generally not recommended	Consider: ≤ 4 weeks	Recommend: ≤ 12 weeks
– reduce out-of-school contacts and community mixing	Generally not recommended	Consider: ≤ 4 weeks	Recommend: ≤ 12 weeks

Interventions by Setting	Pandemic Severity Index		
	1	2 and 3	4 and 5
Workplace/Community			
Adult social distancing			
– decrease number of social contacts (e.g., encourage teleconferences, alternatives to face-to-face meetings)	Generally not recommended	Consider	Recommend
– increase distance between persons (e.g., reduce density in public transit, workplace)	Generally not recommended	Consider	Recommend
– modify, postpone, or cancel selected public gatherings to promote social distance (e.g., stadium events, theater performances)	Generally not recommended	Consider	Recommend
– modify workplace schedules and practices (e.g., telework, staggered shifts)	Generally not recommended	Consider	Recommend

Appendix 3

Daily Influenza like Illness Surveillance

School Name: _____

Week ending: _____

Please e-mail or fax this completed report daily to the Milford Health Department before the end of the school day.

	Monday	Tuesday	Wednesday	Thursday	Friday	
DATE						
TOTAL SCHOOL ENROLLMENT						
NUMBER ABSENT						
NUMBER DISMISSED						
NUMBER DISMISSED WITH ILI*						

*** Influenza like Illness (ILI) is defined by the CDC as fever over 100° F and cough or sore throat.**

Comments:

Appendix 4

H1N1 Vaccination Liability Protections

The following information is compiled for informational purposes only and should not be construed or relied upon as legal advice. It does not represent the official position of the Connecticut Department of Public Health or the state of Connecticut.

I. Protections Under Federal Law

A. The Public Readiness and Emergency Preparedness Act

The Public Readiness and Emergency Preparedness Act (PREP Act) enacted in 2005, added new authorities under the Public Health Service (PHS) Act to alleviate concerns about liability related to the manufacture, testing, development, distribution, administration and use of countermeasures against chemical, biological, radiological and nuclear agents of terrorism, epidemics, and pandemics.

The PREP Act authorizes the Secretary of the Department of Health and Human Services ("Secretary") to issue a declaration (PREP Act declaration) that provides immunity from tort liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats and conditions determined by the Secretary to constitute a present, or credible risk of a future public health emergency to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. A PREP Act declaration is specifically for the purpose of providing immunity from tort liability, and is different from, and not dependent on, other emergency declarations. The PREP Act also authorizes an emergency fund in the United States Treasury to provide compensation for injuries directly caused by administration or use of a countermeasure covered by the Secretary's declaration. While no funds have been appropriated for this purpose, if funds are appropriated, compensation may then be available for medical benefits, lost wages and death benefits to individuals for specified injuries.

A countermeasure covered under a PREP Act declaration can be (1) a qualified pandemic or epidemic product, (2) a security countermeasure, or (3) a drug, biologic product or device authorized for emergency use under an emergency use in accordance with the Federal Food Drug and Cosmetic Act. In response to the current outbreak, FDA issued emergency use authorizations (EUAs) on April 27, 2009 to allow emergency use of 1) oseltamivir (Tamiflu) and zanamavir (Relenza), antiviral medications for treatment and prophylaxis of flu; 2) disposable N95 respirators for use by the general public, and 3) a diagnostic test for H1N1 virus. On June 15, 2009, the Secretary amended the PREP Act declaration for pandemic vaccines to cover H1N1 vaccines.

B. The Federal Volunteer Protection Act

The Federal Volunteer Protection Act of 1997 (FVPA) is a federal law, which extends immunity to volunteers for nonprofit organizations and governmental entities. **It protects volunteers**

(defined as uncompensated except for reimbursement for costs) from economic damages and limits losses for noneconomic and punitive damages, provided the volunteer was acting within scope of responsibilities; if appropriate, is properly licensed, certified or authorized by state authorities; and the harm was not caused through willful, reckless or criminal conduct, gross negligence or gross indifference. **It does not require an emergency declaration to apply. It does not provide protection to the organization and does not provide protection for personnel who are compensated for their services.**

C. Federal Tort Claims Act

Since 2002, federal law has extended the Federal Tort Claims Act (FTCA), which assures that health care professionals who **volunteer during a federally declared Homeland Security disaster** are covered under the Act so long as the individual is, or can be considered, a Federal employee. In extending the definition of a federal employee, the FTCA covers health care professionals who register with Emergency Management Assistance Compacts (EMAC) or Federal initiatives (e.g., National Disaster Medical System) for services rendered under these authorities. 28 U.S.C. §§ 1346(b), 2401(b), 2671-80. (2006). This immunity is only applicable to health professionals who **volunteer** to assist during a federally declared Homeland Security disaster.

II. Protections Under State Law

A. Title 28: Connecticut General Statutes §28-13(a)

Provides **immunity from liability** for “death of or injury to persons or for damage to property as a result of any civil preparedness activity” except in cases of willful misconduct.

Connecticut’s “**civil preparedness**” definition includes “measures to be taken after an attack, major disaster or emergency, including activities for rescue, emergency medical, health and sanitation services...” CGS §28-1(4).

The definition of “**civil preparedness forces**” includes **emergency medical service personnel** licensed or certified under CGS §19a-179 and certain medical responders as follows: The Connecticut Disaster Medical Assistance Team (**DMAT**) and the Medical Reserve Corps, (**MRCs**) under the auspices of the Department of Public Health, **the Connecticut Urban Search and Rescue team**, under the auspices of the Department of Emergency Management and Homeland Security, and the **Connecticut behavioral health regional crisis response teams**, under the auspices of the Department of Mental Health and Addiction Services and the Department of Children and Families. CGS § 28-1(5).¹ Citizen Emergency Response Teams (**CERTs**) are civil preparedness forces according to a formal opinion from the Connecticut Attorney General’s Office. ²

This exemption from liability is applicable to the state, political subdivisions of the state, agents

¹ Civil preparedness forces must take a loyalty oath. CGS §28-12.

² Formal Opinion 2006-016, Attorney General State of Connecticut.

or representatives of the state or any political subdivision of the state and for civil preparedness forces. It also applies anyone employed by or authorized to assist any agency of the federal government in the prevention or mitigation of any major disaster or emergency.

Generally, the immunity from liability would be triggered by a declaration by the Governor. The Governor is authorized to take control of civil preparedness forces and functions after declaring a civil preparedness emergency. CGS §28-9. However, the civil preparedness forces definition specifically states that immunity from liability is available for certain personnel for training activities, which would occur in the absence of a declaration. CGS §28-1(5).

B. Public Health Emergency Preparedness Authority

The Public Health Emergency Response Authority Act (PHERA) CGS §19a-131 et seq. authorizes the declaration of a public health emergency by the Governor. Under a declared public health emergency, CGS §19a-131i provides immunity from personal liability to persons **acting on behalf of the state within the scope of such person's practice or profession and pursuant to sections 19a-131 to 19a-131h**, inclusive, as long as their actions are not wanton, reckless or malicious, and written consent has been obtained for vaccinations.

To be effective, requires a declaration by the Governor of a public health emergency under CGS §19a-131a.

This provision encompasses persons acting on behalf of the state to implement an order issued pursuant to the public health emergency response plan developed under PHERA.

C. Connecticut Good Samaritan Law

Connecticut's Good Samaritan Law, CGS §52-557b(a) states that certain persons, including but not limited to, licensed doctors and dentists, registered nurses and licensed practical nurses, or medical technicians or persons "operating a cardiopulmonary resuscitator or an automatic external defibrillator" under American Red Cross or American Heart Association standards, **who provide emergency medical or professional assistance voluntarily and without compensation and "other than in the ordinary course of such person's employment or practice"** shall not be held civilly liable for injuries caused by negligence. Gross, willful or wanton negligent acts or omissions causing injury are not protected.

Does not require an emergency declaration to be triggered. **The Good Samaritan Law only protects practitioners or other trained persons who provide emergency assistance other than in the ordinary course of their employment, i.e., in a volunteer and unpaid capacity.** It does not apply to health care facilities or to health care practitioners who are providing services for which they are employed, even though the services may be provided in circumstances such as a declared civil preparedness or public health emergency. Good Samaritan statutes generally provide liability protection only for emergency aid at the scene of an emergency.

Appendix 5

Sample permission forms and ideas to improve return of permission forms

<p>KNOX COUNTY HEALTH DEPARTMENT - School FluMist Project Student Consent Form and Live Attenuated Influenza Vaccine Immunization Nursing Record KCHD 5225 REV 7/10/2008 PLEASE PRINT</p> <p>School: _ Home Room Teacher: Grade: __ DOB: _____</p> <p>Last Name: _ First Name: Middle Name: Age: _____</p> <p>Address: City: Zip Code: Home Phone: Emergency Contact Number: Gender: (M / F) _____</p> <p>Primary Language: _ Hispanic: (Y / N) Child's Pediatrician / Physician: _____</p> <p>Race: White Black Asian American Indian Alaskan Native Other: _____</p> <p>Insurance: TennCare _ No Insurance Private Insurance (but does not cover flu vaccination) Private Insurance _____</p> <p>Name of Insurance: ID: Group Number: _____</p> <p>Mother's Last Name: Mother's First Name: MI: _____</p> <p>Father's Last Name: Father's First Name: MI: _____</p> <p>OR, Guardian, if under 18: Last Name: First Name: Relationship: _____</p>		
<p>If you DO NOT want an Influenza Vaccination given to your child, check the DO NOT ADMINISTER BLOCK AND SIGN.</p> <p>_____</p> <p>Parent / Guardian Signature Date</p>		
<p>If you want an Influenza Vaccination given to your child, FILL OUT THE INFORMATION BELOW AND SIGN.</p>		
<p>Please CHECK YES or NO to <u>ALL</u> questions below for the STUDENT.</p> <p>The Nurse giving the vaccination will review the information on vaccination day.</p>	<p>YES</p>	<p>NO</p>
<p>1. Has your child received a "FLU" vaccination before (either Flu Shot or FluMist)?</p>		
<p>2. Has your child received a vaccine within the past 30 days? Name of Vaccine(s): Date Given: _____</p>		
<p>3. Does your child have asthma?</p>		
<p>4. Does your child have chronic heart diseases?</p>		
<p>5. Does your child have diabetes or other metabolic diseases/disorders?</p>		
<p>6. Does your child have kidney diseases?</p>		
<p>7. Does your child have blood diseases?</p>		
<p>8. Has your child ever had a reaction to an injection? If yes, please describe: _____</p>		
<p>9. Is your child allergic to vaccine components, i.e. eggs, gentamicin sulfate, MSG?</p>		
<p>10. Is your child pregnant or nursing?</p>		
<p>11. Has your child ever had Guillain-Barre´ syndrome?</p>		
<p>12. Is your child on long-term aspirin therapy?</p>		
<p>13. Does your child have a disease such as cancer, lupus, HIV/AIDS, or do they take a medication that lowers the body's resistance to infection?</p>		
<p>14. Does your child have close contact with anyone who has had a bone marrow transplant in the last 6 months?</p>		
<p>Please list any allergies: _____</p>		
<p>Additional Notes (use back of page if necessary): _____</p>		
<p>Request for Administration of Influenza Vaccine for the above named recipient: I am aware that the receiver of this vaccine is currently not pregnant nor will become pregnant within four weeks of receiving this vaccine. I have read information about the vaccine and special precautions on the Vaccine Information Sheet. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Knox County Government, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.</p> <p>This Consent Form is valid for administration of influenza vaccinations for six (6) months. It may be used to administer a second dose of influenza vaccine, if needed. I understand that I should report any changes of the above information prior to vaccination.</p>		
<p>_____</p> <p>Parent / Guardian Signature Date</p>		

4) If your child is less than 9 years-old **AND** he/she received the flu vaccine for the first time last year, did he/she get 2 doses? N/A

Yes

No

5) Has your child received a MMR and/or Varicella (chickenpox) vaccine in the past 4 weeks?

Yes

No

6) Does your child have any chronic medical conditions?

Yes

No

If yes, please write the medical condition(s): _____

If your child has asthma how often does he/she use an inhaler? _____
AND

How many times per year does your child see a doctor for asthma?

7) Does your child take aspirin every day?

Yes

No

FOR CLINIC USE ONLY								
Date:	Dose:	Vaccine / Mfg:		Lot # Exp. Date:		Screening MD/RN/LVN	IZ Given By:	Site/Route:
	#1							N / IM
	#2							N / IM

I have read or had explained to me the vaccine information statements for the **Live, Intranasal Influenza Vaccine and/or the Injectable Influenza Vaccine** (Vaccine Information Statement)/??/09). I understand that, depending on the answers to the questions listed above, my child will receive either the injectable or the intranasal flu vaccine at his/her school. I give my permission for my child whose name is listed above to receive the influenza (flu) vaccine.

Parent/Legal Guardian Sign: _____

Date: _____

Ideas for Increasing Return of Consent Forms

Individual incentives

Pencil, eraser, stickers, folders, coupons or extra credit for students returning completed consent forms

Group incentives

May be more effective than individual incentives

Treats (ice cream coupons, pizza) for classes with all students returning completed consent forms

Competition between classes for highest rate of completion

Competition between schools for highest rate of completion

Teacher incentives

Funds for supplies for teachers with 100% completed consent form return

Stipends for workshops for teachers with 100% completed consent form return

Thanking teachers for their work in distributing and collecting consent forms

Student-led initiatives

Funds to a student service club to create posters, announcements

Competition for best posters created by a student

Testimonials by student leaders, athletes

School initiatives to inform/remind parents

School website

Blast faxes

Reverse 911

Blast emails

School newsletter

Note: Complete consent forms include parents signing the form indicating that they do not wish to have their children vaccinated.

Appendix 6 Checklist, Timeline for school located vaccination clinics

The below checklist provides school nurses with a month-by-month guide of activities for hosting a school-based immunization clinic. Please note, activities may vary slightly if working with an immunization partner (e.g., local public health department, Visiting Nurse Association, etc.).

Five to Six Months Prior to School Clinic

- Reach out to administrators/school officials to garner support for vaccination clinic. Inform them of CDC influenza disease recommendations and your desire to conduct a vaccination clinic in the school; enlist their support; identify the steps needed to gain permission.
 - If choosing to work with an immunization partner, reach out to Board of Health members, local public health department or local immunization partner (e.g. Visiting Nurse Association [VNA]) to secure participation and discuss roles (e.g., ordering vaccine, administering vaccine, etc.).
- Complete documentation/processes needed to obtain approval to proceed with clinic.

Three to Four Months Prior to School Clinic

- Select time and date for clinic during school hours.
- Secure clinic location that provides easy access for students, access for emergency medical personnel, if needed (e.g., ground level, wide doors), and access to proper refrigeration of vaccine.
- Order vaccine for use at clinic (e.g., through VaxServe.com or vaccine manufacturer); investigate liability insurance, if applicable.
 - If working with an immunization partner (e.g., health department, VNA) that will provide vaccine, discuss vaccine order (e.g., amount needed, vaccine being used, etc.)
- Tailor template toolkit materials to include information about your clinic:
 - Flyer
 - Parent letter
 - Parent/student educational materials (e.g., fact sheet)
 - Consent/prepayment forms
- Solicit the help of your school PTA to inform parents about the upcoming clinic and assist in coordinating logistics involved in organizing the clinic.
- Contact local health department/local hospitals to assist with promotion of the clinic and solicit available RNs or clerical staff to help administer vaccine during the clinic, if necessary.

Two Months Prior to School Clinic

- Finalize all clinic promotional and informational materials.
 - Send letter along with administrative forms (consent form, Vaccine Information Statement (VIS) sheet, and prepayment form) to parents encouraging registration for vaccination.
 - Display and distribute customized flyer to announce clinic to students and their parents.
 - Host an educational session where parents can obtain additional information about the disease and immunization and distribute flyers, VIS sheets, consent forms, prepayment forms, etc.
 - Host a school assembly to inform students about influenza disease and distribute appropriate materials.
 - Set up a table at back-to-school night or another school event to pass out materials, answer questions from parents about the disease and alert parents to the upcoming clinic.
-

One Month Prior to School Clinic

- Include information about the vaccination clinic in school newsletter, calendar and/or Web site to alert parents and students. Work with PTA to include information in PTA newsletter and announce during meetings.
- Begin collecting consent forms and payment; compile list of students being immunized.
 - Follow up with students with incomplete paperwork (if necessary).
- Begin confirming details for event (e.g., vaccine order status).

Two to Three Weeks Prior to School Clinic

- Arrange for proper handling, storage and disposal of vaccine and medical supplies.
- Begin to make copies and collate materials to be distributed at clinic (e.g., vaccination receipt, immunization provider notification letter, VIS sheet).
- Prepare Vaccination Clinic Record to keep track of immunizations and any other necessary paperwork that need be filed after the clinic.
- Prepare student immunization schedule assigning times for students to be immunized.

One Week Prior to School Clinic

- Remind students who have pre-registered about the clinic; if possible, place calls to parents of children who have registered.
- Remind teachers and administrators about clinic timing; alert them to which students are involved.
- Arrange for school announcements about vaccination clinic.
- Display vaccination clinic flyers around school.
- Finalize logistics for event.

Day of School Clinic

- Arrange for school announcements about vaccination clinic.
- Collect outstanding forms from each person receiving vaccination, or their parents (if under 18), if not yet received.
- Distribute influenza disease and vaccination educational materials, VIS sheets, vaccination receipts and immunization provider notification letters to students being immunized.
- Ensure proper handling, storage, administration and disposal of vaccine and medical supplies.
- Complete necessary paperwork.

After The School Clinic

- File appropriate paperwork with vaccine provider/public health department.
- Record all immunizations with ImmTrac or equivalent federal/state immunization tracker.
- Notify vaccinated students' pediatrician or family physician about immunization status, if applicable.
- Evaluate program success.