

Immunization Pearls

Dane County Immunization Coalition

January 2008

FLU SEASON IS FAR FROM OVER . . .

Peak flu season in Wisconsin is typically toward the end of January and well into February. Therefore, it is not too late to get (or give) a flu vaccination. Since the onset, duration and severity of flu season is unpredictable, and different types and strains of influenza circulate throughout the flu season, CDC's Advisory Committee on Immunization Practices (ACIP) recommends that influenza vaccine be offered as long as influenza viruses are continuing to circulate in the community. Additional information can be obtained at www.cdc.gov/od/oc/media/pressrel/2007/r071109.htm.

FLUMIST GUIDELINES REVISED

While FluMist (live intranasal flu vaccine) has been around for a few years now, the indications for administration and storage changed this past year. It can now be stored in the refrigerator rather than frozen making it much easier to use overall. In addition, the recommended age range has changed to now include children 24-60 months of age as well as healthy individuals age 5 years to 49 years. The volume of vaccine administered with each intranasal dose has also decreased by more than half.

FluMist should not be used in children less than 24 months of age. Other precautions and contraindications are similar to injectable flu vaccine and include: individuals with asthma or wheezing, a history of Guillain-Barre Syndrome, altered immunocompetence, allergies to eggs or other vaccine components, and medical conditions predisposing one to influenza complications. In addition, FluMist should not be used in pediatric and adolescent patients on aspirin therapy. Additional and more specific information can be obtained at www.FluMist.com.

HIB VACCINE PRODUCTS UPDATE

Due to a manufacturing issue, PedVax HIB (PRP-OMP) is currently unavailable for shipment. It may become available again sometime in the fourth quarter of 2008, although that is not certain at this point.

The production suspension is expected to result in short-term disruption to the HIB vaccine supply in the United States. Because of limited availability of the remaining HIB product, ActHIB (PRP-T), the CDC has recommended deferral of the booster dose at 12-15 months except to children in certain high risk groups: children with asplenia, sickle cell disease, human immunodeficiency virus infection and certain other immunodeficiency syndromes, and malignant neoplasms. American Indian/Alaska Native children are also at increased risk for Hib disease and should also continue to receive the full routinely recommended schedule including the 12-15 month booster dose.

PedVax HIB (PRP-OMP), manufactured by Merck, requires a 2 dose primary series at 2 and 4 months and a booster dose at 12-15 months (currently deferred).



PedVax HIB

ActHIB (PRP-T), manufactured by Sanofi Pasteur, requires a 3 dose primary series at 2, 4, and 6 months and a booster dose at 12-15 months (currently deferred).



ActHIB

The vaccines are interchangeable. Children who received PedVax HIB for the first or second dose may be given ActHIB to complete the primary series. (i.e., if more than one brand is used, 3 doses constitute the primary series.)

The immunization registries, WIR and RECIN, will prompt appropriately when the trade names are entered.

ACIP 2008 childhood schedules on pages 2-4:

www.cdc.gov/vaccines/recs/schedules/default.htm

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2008

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹	HepB		HepB		see footnote 1		HepB					
Rotavirus ²				Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis ³				DTaP	DTaP	DTaP	see footnote 3		DTaP			DTaP
Haemophilus influenzae type b ⁴				Hib	Hib	Hib ⁴		Hib				
Pneumococcal ⁵				PCV	PCV	PCV		PCV			PPV	
Inactivated Poliovirus				IPV	IPV			IPV				IPV
Influenza ⁶								Influenza (Yearly)				
Measles, Mumps, Rubella ⁷								MMR				MMR
Varicella ⁸								Varicella				Varicella
Hepatitis A ⁹								HepA (2 doses)			HepA Series	
Meningococcal ¹⁰											MCV4	

Range of recommended ages
 Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 0 through 6 years. Additional information is available at www.cdc.gov/vaccines/recs/schedules. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not

contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for high risk conditions: <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns prior to hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can be delayed, in rare cases, with a provider's order and a copy of the mother's negative HBsAg laboratory report in the infant's medical record.

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered no earlier than age 24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of at least 3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:

- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). (Minimum age: 6 weeks)

- Administer the first dose at age 6–12 weeks.
- Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer any dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).

(Minimum age: 6 weeks)

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. Haemophilus influenzae type b conjugate vaccine (Hib).

(Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHIBit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children age 12 months or older.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])

- Administer one dose of PCV to all healthy children aged 24–59 months having any incomplete schedule.
- Administer PPV to children aged 2 years and older with underlying medical conditions.

6. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- Administer annually to children aged 6–59 months and to all close contacts of children aged 0–59 months.
- Administer annually to children 5 years of age and older with certain risk factors, to other persons (including household members) in close contact with persons in groups at higher risk, and to any child whose parents request vaccination.
- For healthy nonpregnant persons (those who do not have underlying medical conditions that predispose them to influenza complications) ages 2–49 years, either LAIV or TIV may be used.
- Children receiving TIV should receive 0.25 mL if age 6–35 mos or 0.5 mL if age 3 years or older.
- Administer 2 doses (separated by 4 weeks or longer) to children younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time last season, but only received one dose.

7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided 4 weeks or more have elapsed since the first dose.

8. Varicella vaccine. (Minimum age: 12 months)

- Administer second dose at age 4–6 years; may be administered 3 months or more after first dose.
- Don't repeat second dose if administered 28 days or more after first dose.

9. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- HepA is recommended for all children aged 1 yr (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children.

10. Meningococcal vaccine. (Minimum age: 2 years for meningococcal conjugate vaccine [MCV4] and for meningococcal polysaccharide vaccine [MPSV4])

- MCV4 is recommended for children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. Use of MPSV4 is also acceptable.
- Persons who received MPSV4 3 or more years prior and remain at increased risk for meningococcal disease should be vaccinated with MCV4.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

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Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2008

For those who fall behind or start late, see the green bars and the catch-up schedule

Vaccine ▼	Age ►	7-10 years	11-12 years	13-18 years
Diphtheria, Tetanus, Pertussis ¹	<i>see footnote 1</i>		Tdap	Tdap
Human Papillomavirus ²	<i>see footnote 2</i>		HPV (3 doses)	HPV Series
Meningococcal ³		MCV4	MCV4	MCV4
Pneumococcal ⁴		PPV		
Influenza ⁵		Influenza (Yearly)		
Hepatitis A ⁶		HepA Series		
Hepatitis B ⁷		HepB Series		
Inactivated Poliovirus ⁸		IPV Series		
Measles, Mumps, Rubella ⁹		MMR Series		
Varicella ¹⁰		Varicella Series		

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 7–18 years. Additional information is available at www.cdc.gov/vaccines/recs/schedules. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not

contraindicated and if approved by the Food and Drug Administration for that dose of the series. **Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for high risk conditions:** <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

- 1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** (*Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™*)
 - Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids (Td) booster dose.
 - 13–18 year olds who missed the 11–12 year Tdap or received Td only, are encouraged to receive one dose of Tdap 5 years after the last Td/DTaP dose.
- 2. Human papillomavirus vaccine (HPV).** (*Minimum age: 9 years*)
 - Administer the first dose of the HPV vaccine series to females at age 11–12 years.
 - Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
 - Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.
- 3. Meningococcal vaccine.**
 - Administer MCV4 at age 11–12 years and at age 13–18 years if not previously vaccinated. MPSV4 is an acceptable alternative.
 - Administer MCV4 to previously unvaccinated college freshmen living in dormitories.
 - MCV4 is recommended for children aged 2-10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups.
 - Persons who received MPSV4 3 or more years prior and remain at increased risk for meningococcal disease should be vaccinated with MCV4.
- 4. Pneumococcal polysaccharide vaccine (PPV).**
 - Administer PPV to certain high-risk groups.
- 5. Influenza vaccine.**
 - Administer annually to all close contacts of children aged 0–59 months.
 - Administer annually to persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at higher risk.

- Administer 2 doses (separated by 4 weeks or longer) to children younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time last season, but only received one dose.
 - For healthy nonpregnant persons (those who do not have underlying medical conditions that predispose them to influenza complications) ages 2–49 years, either LAIV or TIV may be used.
- 6. Hepatitis A vaccine (HepA).**
 - The 2 doses in the series should be administered at least 6 months apart.
 - HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children.
 - 7. Hepatitis B vaccine (HepB).**
 - Administer the 3-dose series to those who were not previously vaccinated.
 - A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.
 - 8. Inactivated poliovirus vaccine (IPV).**
 - For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child’s current age.
 - 9. Measles, mumps, and rubella vaccine (MMR).**
 - If not previously vaccinated, administer 2 doses of MMR during any visit, with 4 or more weeks between the doses.
 - 10. Varicella vaccine.**
 - Administer 2 doses of varicella vaccine to persons younger than 13 years of age at least 3 months apart. Do not repeat the second dose, if administered 28 or more days following the first dose.
 - Administer 2 doses of varicella vaccine to persons aged 13 years or older at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

Catch-up Immunization Schedule UNITED STATES • 2008

for Persons Aged 4 Months–18 Years Who Start Late or Who Are More Than 1 Month Behind

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS–6 YEARS					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B ¹	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Rotavirus ²	6 wks	4 weeks	4 weeks		
Diphtheria, Tetanus, Pertussis ³	6 wks	4 weeks	4 weeks	6 months	6 months ³
<i>Haemophilus influenzae</i> type b ⁴	6 wks	4 weeks if first dose administered at younger than 12 months of age 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at 15 months of age or older	4 weeks ⁴ if current age is younger than 12 months 8 weeks (as final dose)⁴ if current age is 12 months or older and second dose administered at younger than 15 months of age No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal ⁵	6 wks	4 weeks if first dose administered at younger than 12 months of age 8 weeks (as final dose) if first dose administered at age 12 months or older or current age 24–59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	4 weeks ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months			
Hepatitis A ⁹	12 mos	6 months			
CATCH-UP SCHEDULE FOR PERSONS AGED 7–18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis ¹⁰	7 yrs ¹⁰	4 weeks	4 weeks if first dose administered at younger than 12 months of age 6 months if first dose administered at age 12 months or older	6 months if first dose administered at younger than 12 months of age	
Human Papillomavirus ¹¹	9 yrs	4 weeks	12 weeks		
Hepatitis A ⁹	12 mos	6 months			
Hepatitis B ¹	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	4 weeks ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	4 weeks if first dose administered at age 13 years or older 3 months if first dose administered at younger than 13 years of age			

- 1. Hepatitis B vaccine (HepB).**
 - Administer the 3-dose series to those who were not previously vaccinated.
 - A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.
- 2. Rotavirus vaccine (Rota).**
 - Do not start the series later than age 12 weeks.
 - Administer the final dose in the series by age 32 weeks.
 - Do not administer a dose later than age 32 weeks.
 - Data on safety and efficacy outside of these age ranges are insufficient.
- 3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).**
 - The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
 - DTaP is not indicated for persons aged 7 years or older.
- 4. Haemophilus influenzae type b conjugate vaccine (Hib).**
 - Vaccine is not generally recommended for children aged 5 years or older.
 - If current age is younger than 12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12–15 months and at least 8 weeks after the second dose.
 - If first dose was administered at age 7–11 months, administer 2 doses separated by 4 weeks plus a booster at age 12–15 months.
- 5. Pneumococcal conjugate vaccine (PCV).**
 - Administer one dose of PCV to all healthy children aged 24–59 months having any incomplete schedule.
 - For children with underlying medical conditions administer 2 doses of PCV at least 8 weeks apart if previously received less than 3 doses or 1 dose of PCV if previously received 3 doses.
- 6. Inactivated poliovirus vaccine (IPV).**
 - For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age 4 years or older.
- 7. Measles, mumps, and rubella vaccine (MMR).**
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
 - IPV is not routinely recommended for persons aged 18 years and older.
 - The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
 - If not previously vaccinated, administer 2 doses of MMR during any visit with 4 or more weeks between the doses.
- 8. Varicella vaccine.**
 - The second dose of varicella vaccine is recommended routinely at age 4–6 years but may be administered earlier if desired.
 - Do not repeat the second dose in persons younger than 13 years of age if administered 28 or more days after the first dose.
- 9. Hepatitis A vaccine (HepA).**
 - HepA is recommended for certain groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.
- 10. Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).**
 - Tdap should be substituted for a single dose of Td in the primary catch-up series or as a booster if age appropriate; use Td for other doses.
 - A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. A booster (fourth) dose is needed if any of the previous doses were administered at younger than 12 months of age. Refer to ACIP recommendations for further information. See *MMWR* 2006;55(No. RR-3).
- 11. Human papillomavirus vaccine (HPV).**
 - Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

Information about reporting reactions after immunization is available online at <http://www.vaers.hhs.gov> or by telephone via the 24-hour national toll-free information line 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at <http://www.cdc.gov/vaccines> or telephone, 800-CDC-INFO (800-232-4636).

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NEW SCHOOL IMMUNIZATION REQUIREMENTS

Changes to the administrative rule (chapter HFS 144) governing the immunization of students in Wisconsin will be effective with the start of the 2008-09 school year. These changes affect children in K-12 public and private school settings in Wisconsin as well as pre-kindergarten students and children in day care centers. The intent of the new rules is to:

- Prevent pneumococcal infections, pertussis infections and breakthrough varicella infections among students,
- Update existing rules by deleting obsolete sections and adding clarifying language, and
- Create a clear requirement for disclosure of immunization information

The changes are:

- The addition of pneumococcal infection to the list of diseases against which students in day care centers are to be immunized. The typical series consists of at least 3 doses however, exceptions can be made for children who begin this vaccine series at 12-23 months of age (only 2 total doses required) and children who begin the series at 24 months of age (only 1 dose required).
- The requirement for a single dose of Tdap (Tetanus, reduced diphtheria toxoid, acellular pertussis) for students entering grades 6, 9 and 12 in the 2008-09 school year with full implementation for grades 6-12 by the 2010-11 school year. An exception is made for students who have received a dose of tetanus or diphtheria containing vaccine within the past 5 years.
- The requirement for a second dose of varicella vaccine for students entering grades K, 6, and 12 in the 2008-09 school year with full implementation in all grades by the 2013-14 school year. An exception is made for students who have a reliable history of chicken pox disease.

The language regarding release of immunization information between vaccine providers and schools or day care centers, and among providers, now creates a clear requirement for disclosure rather than a discretionary permission. The previous “written evidence of immunization” is now updated to include electronic records. Finally, the state will be permitted to temporarily suspend a requirement if it determines that because of a vaccine shortage, a student cannot receive required vaccines.

The Dane County Immunization Coalition encourages all primary care providers to review immunization records at each visit and to incorporate these new requirements into their practices. Dane County school districts rely on the Wisconsin Immunization Registry (WIR) for the most up to date immunization information. Providers are encouraged to document varicella history in WIR as well as all immunizations that are given.



HEPATITIS B VACCINE FOR ADULTS AT HIGH RISK

The Wisconsin Hepatitis B Initiative is providing hepatitis B and the combination hepatitis B & A (Twinrix) vaccine through public health to people at high risk for infection.

Public Health—Madison and Dane County is now immunizing adults who self-identify as being in one of these groups:

- household contact or sex partner of someone with chronic hepatitis B infection
- a history of a diagnosed STI
- sexually active, but not in a long-term monogamous relationship
- men who has sex with men
- IV drug users

The immunization is free and the risk factor information is anonymous.

25 monthly, walk-in PHMDC Immunization Clinics each month - 246-4516

Data from the 2004 National Health Interview Survey showed that only 45% of high-risk adults had received hepatitis B immunization. In response to this information, the CDC recommended the following: “To promote vaccination in all settings, health-care providers should implement standing orders to identify adults recommended for hepatitis B vaccination and administer vaccination as part of routine clinical services, not require acknowledgment of an HBV infection risk factor for adults to receive vaccine, and use available reimbursement mechanisms to remove financial barriers to hepatitis B vaccination.” (MMWR, 12.8.2006)

We’ve done well in decreasing hepatitis B in children. We must now work to protect those adults at highest risk for this infection.

2007

BINATIONAL IMMUNIZATION GUIDE:
INTERPRETING IMMUNIZATION SCHEDULES

México → California

This Guide provides information on Mexico's Immunization Schedule, including number of doses and recommended ages. Mexico's schedule is compared side by-side to the "Recommended Childhood and Adolescent Immunization Schedule" followed by health care providers in CA. The Guide also includes information on vaccines available in Mexico in the public sector (this side) and private sector (back).

The Guide facilitates the interpretation of Mexico's Immunization Record and assists health care providers, school staff, and child care providers in assessing immunization records of binational children.

This document follows the format of the "Cartilla Nacional de Vacunación" or National Immunization Record for children and adolescents up to 19 yrs of age.

Produced in collaboration with:



Created by



MEXICO (CARTILLA NACIONAL DE VACUNACIÓN 2007)			CALIFORNIA IMMUNIZATION RECORD PM-286 (1/07)		
VACUNA (VACCINE)	ENFERMEDAD QUE PREVIENE (DISEASE)	EDAD (AGE)	PREVENTABLE DISEASE	VACCINE USED IN CALIFORNIA	AGE
BCG	TUBERCULOSIS	Birth	Tuberculosis	Not Used in California	
ANTIHEPATITIS B (Hep B)	HEPATITIS B	Birth, 2m, 6m	Hepatitis B	Hep B	Birth, 1-2m, 6-18m
PENTAVALENTE ACELULAR * DPdT + VIP + Hib (DTaP + IPV + Hib)	DIFTERIA, TOS FERINA, TÉTANOS, POLIOMELITIS E, INFECCIONES POR H INFLUENZAE TIPO B	2m, 4m, 6m, 18m	Diphtheria, Pertussis, Tetanus, Polio, Hib	DTaP	2m, 4m, 6m, 15-18m
				Hib	2m, 4m, 6m, 12-15m
				Pediarix DTaP + IPV + Hep B	2m, 4m, 6m
				Comvax Hep B + Hib	2m, 4m, 12-15m
DPT (DTP)	DIFTERIA, TOS FERINA, TÉTANOS	4yrs	Diphtheria Tetanus Pertussis	DTaP (Acellular Pertussis)	4-6yrs
ROTAVIRUS	GASTROENTERITIS CAUSADA POR ROTAVIRUS	2m, 4m	Rotavirus	Rotavirus (RV)	2m, 4m, 6m
NEUMOCÓCCICA CONJUGADA 7 Valente (Pneumococcal)	INFECCIONES POR NEUMOCOCO	2m, 4m, 1yr	Pneumococcal	Pneumococcal PCV	2m, 4m, 6m, 12-15m
ANTIINFLUENZA (Influenza)	INFLUENZA	6m-35m (in October and November)	Influenza	INFLUENZA TIV or LAIV ¹ (October-June)	6m-59m
		1m after 1st			4 wks later in the 1st yr vaccinated
		Annually after 35m (in October and November)			Annually up to 59m
TRIPLE VIRAL SRP (MMR)	SARAMPIÓN, RUBÉOLA Y PAROTIDITIS	1yr, 6yrs	Measles, Rubella, Mumps	MMR	12-15m, 4-6yrs
SABIN (OPV)	POLIOMELITIS	During National Vaccination Weeks 6m to 5yrs	Polio	IPV	4-6yrs
Td	TÉTANOS, DIFTERIA	After 12yrs Booster	Tetanus, Diphtheria, acellular Pertussis	Tdap	11-12yrs, catch up to 18yrs
SR (MR)	SARAMPIÓN, RUBÉOLA	Booster	Measles, Rubella	Not Used in California	
ANTIHEPATITIS B ^A (Hep B)	HEPATITIS B	12 yrs, 2nd dose 4m after dose #1	Hepatitis B	Hep B ^A	19m-18yrs, [2 or 3 Doses [⊙]]

^A Catch-up + Needs Additional Dose § Pentavalente = DTaP + IPV +Hib ≠ Pediarix = DTaP + IPV + Hep B
 ≠ Not Equivalent ⊙ Number of Doses Depends on Vaccine Product *Pentavalente Given Prior to 2007 contained DTP + Hep B + Hib
 Triple Viral SRP = MMR
¹ LAIV is licensed for healthy people 2-49 years

www.dhs.ca.gov/ps/dcdc/izgroup/pdf/Guide1_MX%20to%20CA.pdf



IS ALUMINUM THE NEW THIMEROSAL?

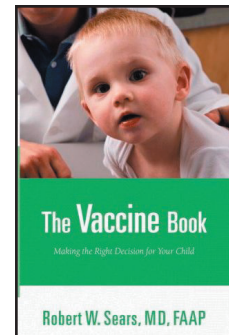
There has been an increase in calls to the Madison & Dane Co. public health department from parents inquiring about the additives and preservatives in vaccines as well as the manufacturing process. The calls concerning Thimerosal have steadily decreased, and the focus has turned to aluminum. It seems as if Dr Sears' The Vaccine Book is having an impact. Dr Robert Sears has published a book called The Vaccine Book, where he encourages an "alternate" vaccine schedule to greatly reduce the aluminum exposure that the baby receives. Dr Sears also discusses in great detail all of the ingredients in vaccines and the amounts of certain components within vaccines. He encourages parents to request certain brands of vaccines due to their reduced aluminum content. As a result, parents have been calling around to local clinics and the public health department, asking if these brands are carried. One health care provider has stated that a parent became so infuriated when they refused to order their requested vaccine brand, that they filed a complaint with the medical director of the clinic.

In this particular section, aluminum is discussed, and Dr Sears starts out by explaining that aluminum is naturally occurring and present in our every day environment and thought to be harmless. However, he continues in the next few pages to list the micrograms of aluminum in each vaccine, stating that it ranges from 0 mcg-1,500 mcg per injection, varying from a single antigen vaccine to combination vaccines. He then compares this amount of aluminum to that in that of IV fluids and parenteral nutrition solution. According to a label on the aluminum content in injected dextrose solution, aluminum content may reach toxic levels with prolonged parenteral administration if kidney function is impaired. Neonates who receive aluminum levels of greater than 4 to 5 micrograms per kg of body weight accumulate aluminum at levels associated with CNS and bone toxicity (page 195). Dr. Sears continues to state that the FDA has deemed that a healthy 12 lb, 2 month old baby can safely receive at least 30 mcg of aluminum in one day. Considering that the aluminum content in vaccines ranges from 0-1,500 mcg, it is very concerning that parents may consider not vaccinating their children.

The alternative schedule is listed on pages 236 and 237 of The Vaccine Book and is as follows:

2 months: DTaP, Rotavirus
 3 months: PCV4, HIB
 4 months: DTaP, Rotavirus
 5 months: PCV4, HIB
 6 months: DTaP, Rotavirus
 7 months: PCV4, HIB

9 months: IPV, Flu
 12 months: Mumps, IPV
 15 months: PCV4, HIB
 18 months: DTaP, Varicella
 21 months: Flu
 2 years: Rubella, IPV
 2 years, 6 months: Hep B, Hep A
 3 years: Hep B, Measles, Flu
 3 years, 6 months: Hep B, Hep A
 4 years: DTaP, IPV, Flu
 5 years: MMR, Flu
 6 years: Varicella
 12 years: Tdap, HPV
 12 years, 2 months: HPV
 13 years: HPV, MCV4



There are many concerns about this alternative schedule because Dr Sears doesn't feel that it is necessary to give Hep b vaccine prior to age 2-1/2 because he feels that children are not at risk for contracting it and also it is tested for during the prenatal period. With this schedule, it would require 8 trips to the health care provider for non-acute needs in the first year alone. This sets the child up to fall behind from the start. It lacks a realistic and common sense approach to the prevention of vaccine preventable disease.

The recent edition of Mothering Magazine also devoted eight full pages to Dr Sears claims that vaccines contain toxic levels of aluminum. This may have devastating consequences for the public's health if a large number of parents decide to follow Dr Sears' advice. It seems that vaccines have become a victim of their own success. Parents no longer see vaccine preventable diseases that have resulted in morbidity and mortality such as polio and rubella. The fear of disease is now being replaced with the fear of vaccines.

Aluminum adjuvants are used in certain vaccines to help stimulate the production of immunity against the vaccine ingredients, making the vaccine more effective. Studies have shown that many aluminum-containing vaccines cause higher and more prolonged antibody responses than comparable vaccines without the adjuvant.

Aluminum-containing vaccines have more than a 75-year record of safety around the world. Serious adverse effects attributable to the aluminum adjuvants are rare.

For more information:

www.i4ph.org/vaccine_components_detail.cfv?id=61

RECOMMENDATION FROM ACIP FOR USE OF QUADRIVALENT MENINGOCOCCAL CONJUGATE VACCINE (MCV4) IN CHILDREN AGED 2-10 YEARS AT INCREASED RISK FOR INVASIVE MENINGOCOCCAL DISEASE

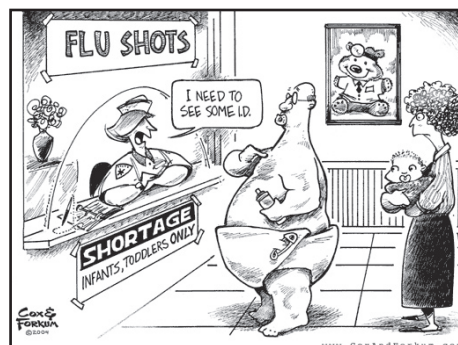
On October 17, 2007, the Food and Drug Administration approved quadrivalent meningococcal conjugate vaccine (MCV4) (Menactra®, Sanofi Pasteur) for use in children aged 2-10 years, in addition to its prior approval for use in persons aged 11-55 years. Previous Advisory Committee on Immunization Practices (ACIP) recommendations called for routine vaccination with meningococcal polysaccharide vaccine (MPSV4) (Menomune®, Sanofi Pasteur) of children aged 2-10 years who are at increased risk for meningococcal disease. These children include travelers to or residents of countries in which meningococcal disease is hyperendemic or epidemic, children who have terminal complement component deficiencies, and children who have anatomic or functional asplenia.

At its October meeting, ACIP revised its recommendation to state that MCV4 is preferable to MPSV4 for vaccination of children aged 2-10 years who are at increased risk for meningococcal disease. These children include travelers to or residents of countries in which meningococcal disease is hyperendemic or epidemic, children who have terminal complement component deficiencies, and children who have anatomic or functional asplenia. Additionally, MCV4 is preferred to MPSV4 for use among children aged 2-10 years for control of meningococcal disease outbreaks. Providers may elect to vaccinate children aged 2-10 years who are infected with human immunodeficiency virus (HIV). For children aged 2-10 years who have previously received MPSV4 and remain at increased risk for meningococcal disease, ACIP recommends vaccination with MCV4 at 3 years after receipt of MPSV4. Children who last received MPSV4 more than 3 years ago and remain at risk for meningococcal disease should be vaccinated with MCV4 as soon as possible. For children at lifelong increased risk for meningococcal disease, subsequent doses of MCV4 likely will be needed. ACIP will make recommendations for revaccination with MCV4 as more data on duration of protection become available.

Persons with a history of Guillain-Barré syndrome (GBS) might be at increased risk for GBS after MCV4 vaccination; therefore, a history of GBS is a precaution to administering MCV4. For children with a history of GBS, MPSV4 is an acceptable alternative for short-term (i.e., 3-5 years) protection against meningococcal disease.

The ACIP meningococcal vaccine workgroup is considering options for general use of MCV4 among children aged 2-10 years. Recommendations will be presented at a future ACIP meeting. Recommendations for use of MCV4 in persons aged 11-55 years, including a recommendation for routine vaccination with MCV4 of persons aged 11-18 years, have been published previously and remain unchanged.

For full article, please visit: www.cdc.gov/mmwr/preview/mmwrhtml/mm5648a4.htm



VIS SHEET UPDATES

The use of the most Vaccine Information Statements (VISs) is mandated by federal law. Listed below are the dates of the most current VISs. Check your stock against this list. Replace outdated VISs. VIS sheets can be found at:

www.cdc.gov/nip/publications/vis or
www.immunize.org/vis

(IAC has VISs in more than 30 languages).

DTaP (5/17/07)
Hepatitis A (6/15/06)
Hepatitis B (7/18/07)
HPV (2/2/07)
Influenza (7/27/07)
Meningococcal (1/28/08)
Rabies (1/25/06)
Rotavirus (1/10/07)
Tdap (7/12/06)
Varicella (1/10/07)
Zoster (10/13/06)
Multi-vaccine VIS (1/30/08)

Download for new multi-vaccine VIS:

www.cdc.gov/vaccines/pubs/vis/downloads/vis-multi.pdf

HPV VACCINE AND CONSENT

As of September 13, 2007, Family Planning Clinics in Wisconsin have been encouraged to enroll in the Vaccines For Children (VFC) program so that they may provide the HPV vaccine to VFC eligible minor females aged 9-18. The advantage of this is that some girls may want to receive this vaccine without parental consent, and may do so at Family Planning Clinics due to the Family Planning Waiver extension that includes HPV vaccine as part of reproductive health care. The Family Planning Waiver does not cover the cost of the vaccine if the client is not VFC eligible. Unfortunately, many Family Planning Clinics and Planned Parenthood Clinics have opted to not take advantage of this availability yet.

Currently, Public Health Madison & Dane Co. has consent policies in place that require the consent of a parent or legal guardian for all vaccines to be given to a minor. This consent policy is congruent to legal statutes that have been interpreted by the legal counsel for public health. Every health care facility is responsible for developing their consent policies since there is not an official state or federal consent policy.

Since many Planned Parenthood and Family Planning Clinics in Dane County have not pursued VFC eligibility status, those interested in receiving the HPV vaccine without parental consent are encouraged to call Family Planning and Planned Parenthood Clinics to see if they are offering it yet.

One thing to note is that the WIR allows access for parents to view their child's vaccine record and the HPV vaccine would be listed on the record, so parents may view this information. It will not disclose where the vaccine was given.

Planned Parenthood of Wisconsin

2202 South Park, Suite 400
Madison, WI 53713
608-261-9256

Planned Parenthood of Wisconsin

416 West Mifflin
Madison, WI 53703
608-256-7257

Planned Parenthood of WI

3706 Orin Road
Madison, WI 53704
(608) 241-3837

First Choice Woman's Health Center

1015 Burbank Avenue
Janesville, WI 53546
608-755-2438

Planned Parenthood of Wisconsin

204 East Edgewater, Suite 202
Portage, WI 53901
608-742-1551

Sauk Co. Health Dept.

West Square Building
505 Broadway
Baraboo, WI 53913
608-355-4300

Family Planning Health Services, Inc. - Juneau County

234-A West State Street
Mauston, WI 53948
608-847-6568

Planned Parenthood of Wisconsin

96 Stoddart St.
Beaver Dam, WI 53916
920-885-3528

Planned Parenthood of Wisconsin

333 North Peters Ave.
Suite 6
Fond du Lac, WI 54935
920-922-9884

Planned Parenthood of Wisconsin

1520 11th Street
Monroe, WI 53566
608-325-5005

Marquette Co. Health Dept

480 Underwood Ave
PO Box 181
Montello, WI 53949
608-297-9116

Planned Parenthood of Wisconsin

202 C Village Walk Lane
Johnson Creek, WI 53038
920-699-4720

Planned Parenthood of Wisconsin

312 S. 7th Street
Delevan, WI 53115
262-728-1849

REPUTABLE VACCINE INFORMATION RESOURCES

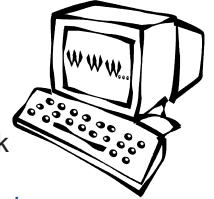
- ✓ National Network for Immunization Information
www.immunizationinfo.org
- ✓ National Immunization Program
www.cdc.gov/nip
- ✓ American Academy of Pediatrics
www.aap.org
- ✓ Immunization Action Coalition
www.immunize.org
- ✓ American Public Health Association
www.apha.org
- ✓ Institute for Vaccine Safety (John Hopkins University)
www.vaccinesafety.edu
- ✓ Infectious Diseases Society of America
www.idsociety.org
- ✓ Vaccine Education Center
www.vaccine.chop.edu



Check it out!

Dane County Immunization Coalition's website:
www.cityofmadison.com/health/coalitions/dcic.html

- ✓ Minutes from the General Membership meetings
- ✓ 2007 Immunization Schedules
- ✓ Public Health's immunization clinic schedules
- ✓ Media Campaigns
- ✓ Membership
- ✓ Coalition Goals & Impact



The Coalition welcomes your feedback and suggestions for website content!

Contact: jluebkecleary@publichealthmdc.com



UPCOMING EVENTS:

National Immunization Conference
March 17-20, 2008
Hilton Atlanta
Atlanta, Georgia



www.cdc.gov/vaccines/events/nic/

DANE COUNTY IMMUNIZATION COALITION

www.cityofmadison.com/health/coalitions/dcic.html

Immunization PEARLS brought to you by the Immunization Practices Committee

Public Health - Madison & Dane County
Jeneile Luebke Cleary, Cheryl Robinson

Madison Metropolitan School District
Freddi Adelson

UW Medical Foundation
Sandy Jacobson

UW Department of Family Medicine
Maureen Van Dinter

Group Health Cooperative SC-W
Linda Capener

Dean Health Care
Jill Jensen

