Immunization FAQ Sheet
Required Vaccines for 2009-10 School Year

Scheduling and Documentation

1. Question: Is there a ‘grace period’ for vaccines that are given earlier than the required age?
   Answer: Yes. The rule is: “vaccine doses administered ≤ 4 days before the minimum interval or age are to be counted as valid.” For example, if MMR or Varicella is given more than 4 days before the 1st birthday, the dose is to be repeated.

2. Question: What is the difference between the “recommended” vaccine schedule and the “required” vaccine schedule?
   Answer: The “recommended” vaccine schedule is the optimum schedule approved by the Advisory Committee on Immunization Practices (ACIP) and is an immunization “best practice” for protecting children against vaccine preventable disease. It is a more stringent schedule than Colorado’s “required” vaccine schedule, and those health care providers and clinics who administer vaccines following the ACIP guidelines are providing optimum coverage for Colorado’s children. The “required” vaccine schedule includes those vaccines “minimally” required for school entry by the Colorado Board of Health (BOH). The “required” vaccine schedule can be located in Tables 1 & 2 in the “Rules of the Colorado Board of Health” located on the Colorado Department of Public Health and Environment’s immunization web site:

   http://www.cdphe.state.co.us/regulations/diseasecontrol/100902infantimmunizationprogram.pdf

3. Question: There are times when an immunization record will not include a complete date of administration. If a full date is not available, what is the “default date” for recording a vaccine in the record?
   Scenario #1: If the vaccine administered is MMR or Varicella and the dose in question was administered at 12 months in the birth month of the child (e.g. the parent’s record indicates a dose of MMR was administered on 12/2001 and the child’s birth date is 12/5/2000).
   Answer: The dose should only be counted and recorded in a new clinic record if the month, day and year of the vaccine administration are recorded. If the day the vaccine was administered is not noted, reasonable attempts should be made to obtain the exact day. If this information is not available/located, the dose SHOULD NOT BE COUNTED.
Scenario #2: If the vaccine administered is MMR or Varicella and the dose in question was administered at least 12 months after the birth month of the child (e.g. the parent’s record indicates a dose of MMR was administered on 12/2001 and the child’s birth date is 11/9/2000).
Answer: The dose should be counted and recorded in a new clinic record if the month, day and year of the vaccine administered are recorded. If the day the vaccine was administered is not noted, reasonable attempts should be made to obtain the exact day. If this information is not available or located, the dose should be recorded as the 15th of the month noted (e.g. the parent’s record indicates a dose of MMR was administered on 12/2001 and the child’s birth date is 11/9/2000). If the exact day the dose was administered cannot be obtained through reasonable efforts, the dose of MMR should be recorded as 12/15/2001).

Scenario #3: If any other dose of vaccine is administered (other than MMR or Varicella).
Answer: The dose should be counted and recorded in a new clinic record if the month, day and year of the vaccine administration are recorded. If the day the vaccine was administered is not noted, reasonable attempts should be made to obtain the exact day. If this information is not available/located, the dose should be recorded as the 15th of the month noted (e.g. the parent’s record indicates a dose of Hepatitis B was administered on 12/2001. If the exact day the dose was administered cannot be obtained through reasonable efforts, the dose of Hepatitis B should be recorded as 12/15/2001).

Varicella Vaccination and Chickenpox Disease

4. Question: What are the grade level requirements for the 1st and 2nd doses of Varicella vaccine?
Answer: 1 dose of Varicella will be required for students in 3rd through 9th grades. 2 doses are required at Kindergarten, 1st and 2nd grades.

5. Question: Is documentation of chickenpox disease required to come from a health care provider?
Answer: Yes. A healthcare provider diagnosis of disease or verification/screening and documentation of history of chickenpox disease is now required. For all children who have parent-reported cases of chickenpox disease noted on their current Certificate of Immunization prior to the 2007-2008 school year, that documentation will be accepted. For all children new to the Colorado school system and for all children who do not have chickenpox disease recorded on the Certificate of Immunization prior to the 2007-2008 school year, they must now have documentation of the disease by a health care provider (physician or RN) or a laboratory confirmation showing immunity to the disease.

6. Question: Why does chickenpox disease need to be documented by a health care provider?
Answer: The intent of the board of health requirement is to consistently implement the national recommendations of the Advisory Committee on Immunization Practices (ACIP). It is recommended that suspected chickenpox disease or history of chickenpox disease be documented in the child’s medical record by their primary care provider. Health care providers who are not the child’s primary care provider can encourage the parent to utilize the medical home model by establishing care with a primary care provider.

7. Question: Can a public health nurse or a school health nurse document history of chickenpox?
Answer: Yes. For the purposes of facilitating this requirement for documentation of chickenpox
8. **Question:** What is considered acceptable **documentation of a history of chickenpox disease**?

**Answer:** The documentation of disease may come from the child’s medical record, be noted on a prescription pad or on an alternate form that comes from the provider’s office. If a public health nurse or a school nurse screens for the disease history and determines the child has had chickenpox, he/she can record the date in the appropriate box in the Certificate of Immunization.

9. **Question:** In obtaining a reliable history of chickenpox, how are both **primary infection** and **breakthrough disease** identified?

**Primary Infection (Chickenpox):** In children, the rash is often the first sign of disease. The rash is generalized and itchy and progresses rapidly from macules to papules to vesicular lesions before crusting. It typically appears first on the head, then on the trunk and then the extremities; the highest concentration of lesions is on the trunk. Lesions also occur on mucous membranes of the oropharynx, respiratory tract, vagina, conjunctiva, and the cornea. Vesicles may rupture (clear liquid) or become purulent before they dry and crust. Healthy children usually have 200 to 500 lesions in 2 to 4 successive crops over several days. The clinical course is generally mild, with malaise, itching and a temperature up to 102 degrees F for 2 – 3 days. *(Epidemiology and Prevention of Vaccine-Preventable Diseases, 10th Edition, January 2007, page 176).* Photos of chickenpox disease can be viewed at: [www.cdphe.state.co.us/dc/epidemiology/Varicella](http://www.cdphe.state.co.us/dc/epidemiology/Varicella)

**Breakthrough Disease:** Breakthrough disease is defined as a case of infection with wild-type Varicella Zoster Virus occurring >42 days after vaccination. Usually, the median number of skin lesions is < 50 and the lesions are atypical, with papules that do not progress to vesicles. The duration of illness is shorter and there is lower incidence of fever. *(MMWR, June 22, 2007/Vol. 56/No. RR-4, page 14).* The Centers for Disease Control recommend that a physician (or designee) verify history or diagnosis of atypical disease and include either an epidemiologic link to a typical varicella case or provide evidence of laboratory testing at the time of acute disease. When such documentation is lacking, a person should not be considered as having a valid history of disease, because other diseases may mimic mild atypical varicella. *(Epidemiology and Prevention of Vaccine-Preventable Diseases, 10th Edition, January 2007, page 189).* If a school nurse or public health nurse does not feel that the report of disease is reliable, provide education and refer to clinic for vaccine.

**Tdap/Td/DTaP & Hepatitis B**

10. **Question:** What grades are required to have **Tdap** (Tetanus, Diphtheria, Pertussis) vaccine for the 2009-10 school year?

**Answer:** Tdap will be required for all incoming 6th, 7th, 8th, and 10th, 11th, 12th graders in the 2009-10 school year.

11. **Question:** How soon after a child has had a **Td** vaccination will a **Tdap** vaccination be required?

**Answer:** For students required to have the vaccination for school entry, Tdap will need to be given 2
years after a Td vaccination has been administered (5 year interval between DTaP and Tdap).
Colorado has a high incidence of Pertussis disease and an adolescent with the disease can easily infect other children in the home. It is expected that this immunization requirement will decrease the incidence Pertussis in Colorado. (CDC reports that there is no absolute minimum interval between Td and Tdap).

The following publication provides detailed information on Tdap:
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5517a1.htm?s_cid=rr5517a1_e

12. **Question**: What is the difference between the 2 tetanus/diptheria/pertussis containing vaccines, DTaP and Tdap?

   **Answer**: DTaP is the vaccine licensed for children ages 6 weeks to 6 years of age and is administered in a series of 4 or 5 doses depending on when the last dose was given. DTaP is not to be administered to children 7 years and older. Tdap is the vaccine that is licensed for children beginning at ages 10 or 11 years (Boostrix -10 to 64 years of age and Adacel for 11 to 64 years of age. There is no pertussis containing vaccine for children 7 to 9 years of age so when considering compliance for these kids, we are looking to make sure that they have 3 appropriately spaced tetanus/diptheria containing vaccines (DTaP, DT, Td). Three appropriately spaced tetanus/diptheria containing vaccines includes a minimum interval of 4 weeks between dose 1 and 2 and a 6 month interval between dose 2 and 3.

13. **Question**: Some physicians are unwilling to administer a Tdap 2 years after a Td has been given. What is the best course of action so that students can be in compliance with the immunization laws?

   **Answer**: If a physician is unwilling to sign a medical exemption, then the parent may consider taking their child to a health department to have the vaccine administrated or they can opt to sign a personal exemption so the child will be in compliance with the immunization law. A letter from the physician stating that the child did not receive the required vaccine does not meet the school immunization requirement for compliance.

13. **Question**: What is the requirement for Hepatitis B (Hep B) vaccine?

   **Answer**: For those students in child care, preschool and K – 12th grades who have had 3 doses of Hep B irregardless of the minimum intervals prior to the 2009-10 school year, those doses will be accepted as valid through the remainder of their years in the Colorado School system. For students new to the Colorado school system and for students who have not completed the 3 dose series of Hepatitis B vaccine prior to the 2009-10 school year, those doses must follow minimum intervals as established by ACIP. The minimum intervals include 4 criteria as follows: The second dose should be administered at least 4 weeks after the first dose, and the third dose should be administered at least 16 weeks after the first dose and at least 8 weeks after the second dose. The final dose is to be administered at 24 weeks of age (6 months of age) and is not to be administered prior to that age.

   There is a 2 dose series available for students 11 to 15 years of age. A student provides written documentation from a licensed physician that the student has received two doses of Recombivax HB using the adult dose (1.0 ml containing 10 μg of hepatitis b surface antigen), with the second dose given 4 to 6 months after the first dose. The specific name of the vaccine, the exact dose of antigen per injection, and the dates of administration must be included as part of the documentation. In lieu of immunization, written evidence of a laboratory test showing immunity is acceptable.

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