

Dear Employee,

If this is your first “TDY OCONUS Immunization” appointment with our clinic, please bring all immunization records with you to your appointment (or you can attach them to your paperwork file).

If you do not have any immunizations records and your appointment is in 2 weeks or more, we can order lab work for you to have titers drawn to check for immunity. We can only do titers for the Measles, Mumps and Rubella (MMR), Varicella (chickenpox) and Hepatitis B vaccines. Positive titers tell us that you have immunity and negative titers mean you do not. Based on titer results you may need those vaccines as well as any other vaccines required by the Area of Responsibility (AOR).

If you would like to have titers drawn for one or all 3-viruses listed above, then please call our clinic so we can put the lab order(s) in for you. Your labs will be drawn here at Fox Army Health Center in the laboratory. We ask that you have these labs drawn at least 7 business days prior to your appointment date so we will have the results back. Our clinic number is (256) 955-8888 x-1026.

Thank you,

Occupational Health Clinic Team

OCCUPATIONAL HEALTH SCREENING FORM

Reason for Visit:

Date:

Patient Information						
Name	DOB	DoD ID or Full SSN:				
Organization/Program		Job Title & Job Series				
Work Number	Cell Number:					
Email:	Supervisor:	Supervisor's Phone:				
Personal medical history (check all that apply)						
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; border-right: 1px solid black; padding-right: 10px;"> ☐ No known medical conditions ☐ Allergies (Drug, Food, Environmental) ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Autoimmune Disorder (Specify: _____) ☐ Cancer (Specify: _____) ☐ Congestive heart failure ☐ COPD / Emphysema ☐ Depression ☐ Diabetes (Type 1 / Type 2) ☐ Epilepsy / Seizures ☐ GERD (Acid Reflux) ☐ Glaucoma ☐ Gout </td> <td style="width: 50%; vertical-align: top; padding-left: 10px;"> ☐ Heart Attack / Heart Disease ☐ High Blood Pressure (Hypertension) ☐ High Cholesterol ☐ HIV/AIDS ☐ Kidney Disease / Kidney Stones ☐ Liver Disease / Hepatitis ☐ Migraines ☐ Osteoporosis ☐ Sleep Apnea ☐ Sleep: Insomnia/Difficulties ☐ Stroke ☐ Substance Abuse (Alcohol / Drugs) ☐ Thyroid Disease (Hypo / Hyper) ☐ Tuberculosis ☐ Ulcers </td> </tr> </table>					☐ No known medical conditions ☐ Allergies (Drug, Food, Environmental) ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Autoimmune Disorder (Specify: _____) ☐ Cancer (Specify: _____) ☐ Congestive heart failure ☐ COPD / Emphysema ☐ Depression ☐ Diabetes (Type 1 / Type 2) ☐ Epilepsy / Seizures ☐ GERD (Acid Reflux) ☐ Glaucoma ☐ Gout	☐ Heart Attack / Heart Disease ☐ High Blood Pressure (Hypertension) ☐ High Cholesterol ☐ HIV/AIDS ☐ Kidney Disease / Kidney Stones ☐ Liver Disease / Hepatitis ☐ Migraines ☐ Osteoporosis ☐ Sleep Apnea ☐ Sleep: Insomnia/Difficulties ☐ Stroke ☐ Substance Abuse (Alcohol / Drugs) ☐ Thyroid Disease (Hypo / Hyper) ☐ Tuberculosis ☐ Ulcers
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Other medical issues:						
Medications						
Name(s)	Dosage(s)	Frequency	Reason for Taking	Note(s)		
Medication Allergies/Reaction Name of Medication(s): ☐ No medication allergies Reaction(s):						
Allergy to Latex: Yes ☐ No ☐ If yes, reaction:						

Surgeries (site and date)		
Social history		
Factor	Check one	Most recent date (if applicable)
Tobacco Use	☐ Cigarettes ☐ Cigars ☐ Chew/Dip ☐ Vape ☐ Quit ☐ Never Used	
Alcohol Use	☐ Occasional ☐ Moderate ☐ Heavy ☐ Don't Drink	
Caffeine (Coffee, Tea, Soda, Energy Drinks)	☐ No ☐ Yes (amount per day)	
Pre/Post Workout Supplements	☐ No ☐ Yes [] Times per week	
Exercise Routine	[] Times per week	
Sleep	[] Hours a night	
Living Situation: ☐ With roommates ☐ With S/O ☐ With family ☐ Other:		
Additional Notes <i>By providing my name (full name: first and last), date of birth (DOB) and today's date, I hereby certify that, to the best of my knowledge, the above provided information is true and accurate.</i> Patient name: _____ DOB: _____ Date: _____		
Staff Section: Vitals: Height: _____ Weight: _____ BMI: _____ BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____ Repeat vitals: Nurses Notes: Providers Notes:		

Routine Immunization Screening Form: Adult

NOTE: If cholera or smallpox vaccines are being considered, please complete their respective immunization screening forms.

AUTHORITY:	10 U.S.C. 1071-1085, Medical and Dental Care; Army Regulation 40-562, Immunizations and Chemoprophylaxis for the Prevention of Infectious Disease; DoDM 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs.
PURPOSE:	To determine whether you can safely receive a routine immunization.
ROUTINE USES:	Use and disclosure of your records outside of DoD may occur in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Collected information may be shared with entities including the Departments of Health and Human Services, Veterans Affairs, and other Federal, State, local, or foreign government agencies, or authorized private business entities. To appropriate agencies, entities, and persons when (1) the DoD suspects or has confirmed that there has been a breach of the system of records; (2) the DoD has determined that as a result of the suspected or confirmed breach there is a risk of harm to individuals, the DoD (including its information systems, programs, and operations), the Federal Government, or national security; and (3) the disclosure made to such agencies, entities, and persons is reasonably necessary to assist in connection with the DoD's efforts to respond to the suspected or confirmed breach or to prevent, minimize, or remedy such harm.
APPLICABLE SORN:	EDHA 07, Military Health Information System (November 18, 2013, 78 FR 69076) https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570672/edha-07/
DISCLOSURE:	Voluntary. If you choose not to provide the requested information, no penalty may be imposed; however, failure to provide the information may result in delays in assessing contraindications for receiving vaccinations.

Patient name:

DOB (YYYYMMDD):

Screening Checklist for Contraindications to Vaccines for Adults

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
3.	Do you have allergies to medication, food, a vaccine component, or latex?	☐	☐	☐
4.	Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
5.	Have you had a health problem involving heart, lung (e.g., asthma), kidney, or metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
6.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
7.	In the past 3 months, have you taken medications that weaken your immune system, such as prednisone or other steroids; anticancer drugs; biologic drugs for autoimmune diseases such as rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
8.	In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9.	Have you had (or are you a candidate for) your spleen removed, or do you have sickle cell anemia?	☐	☐	☐
10.	Have you ever passed out (had vasovagal syncope) during or after a previous immunization or blood draw?	☐	☐	☐
11.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
12.	Are you pregnant or is there a chance you could become pregnant during the next month?	Not Applicable ☐	☐	☐

Please list any medications you are currently taking:

Form completed by:

Date (YYYYMMDD):

Form reviewed by:

Date (YYYYMMDD):

Did you bring your immunization record/card with you?

Yes ☐ No ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it. For questions or concerns regarding immunizations, providers, nurses and patients may call the DHA Immunization Healthcare Support Center 24/7 at 1-877-438-8222, Option 1.

Information for Healthcare Professionals about the Screening Checklist for Contraindications (Adult)

Each screening question is explained in more detail below. For more information, please consult the sources referenced at the end.

1. Are you sick today? [all vaccines]

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events.¹ However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Have you ever had a serious reaction after receiving a vaccination? [all vaccines]

History of anaphylactic reaction (see question 3) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses.¹ History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. There are other adverse events that may occur following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

3. Do you have allergies to medications, food, a vaccine component, or latex? [all vaccines]

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers or caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. For patients with known Alpha-gal syndrome (red meat allergy), caution should be exercised with gelatin-containing vaccines (i.e. MMR, VAR, YF-Vax), as some of these patients have demonstrated anaphylaxis with these vaccines. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component.^{2,3} People with egg allergy of any severity can receive any recommended influenza vaccine (i.e., any IIV or RIV) that is otherwise appropriate for the patient's age. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administered in a medical setting, such as a clinic, health department, or physician's office. Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.⁴

4. Have you had a seizure, or had brain or other nervous system problems?

[IIV, LAIV, Td, Tdap]

Tdap is contraindicated in patients who have a history of encephalopathy within 7 days following DTP/DTaP given as a child. An unstable, progressive neurologic condition is a precaution to the use of Tdap. For patients with stable neurologic disorders (including seizures) unrelated to vaccination, or for patients with a family history of seizures, vaccinate as usual. A history of Guillain-Barre syndrome (GBS) is a precaution for the following: 1) Td/Tdap: if GBS occurred within 6 weeks of a tetanus-containing vaccine and the decision is made to continue vaccination, if no history of prior Tdap, give Tdap instead of Td; 2) Influenza vaccine (IIV or LAIV): if GBS occurred within 6 weeks of a prior influenza vaccination, vaccinate with IIV if at high risk for severe influenza complications.

5. Have you had a health problem involving heart, lung (e.g., asthma), kidney, or metabolic disease (e.g., diabetes), anemia, or other blood disorder? [MMR, LAIV, SPV]

A history of thrombocytopenia or thrombocytopenic purpura is a precaution to MMR vaccine. The safety of LAIV in patients with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for LAIV use.

6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?

[Adenovirus, Cholera, LAIV, MMR, SPV, Ty21a, VAR, YF-Vax, ZVL]

Live virus vaccines are usually contraindicated in immunocompromised patients; however, there are exceptions. MMR is recommended and varicella should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200cell/ μ L. Immunosuppressed patients should not receive LAIV. For details, consult current ACIP recommendations.^{1,6,7,8}

7. In the past 3 months, have you taken medications that weaken your immune system, such as prednisone or other steroids; anticancer drugs; biologic drugs for autoimmune diseases such as rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? [Adenovirus, Cholera, MMR, SPV, Ty21a, VAR, YF-Vax, ZVL]

Live virus vaccines should be postponed until after chemotherapy or long-term, high-dose steroid therapy has ended. For details and length of time to postpone, consult the current ACIP statement.¹ Some immune mediator and immune modulator drugs (especially the antitumor necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. The use of live vaccines should be avoided in persons taking these drugs.¹ Specific vaccination schedules for stem cell transplant (bone marrow transplant) patients can be found on the NIH website.⁸ LAIV, when recommended, can be given only to healthy, non-pregnant people ages 2 through 49 years.

8. In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?

[MMR, VAR]

Certain live virus vaccines may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for information on intervals between receipt of antiviral drugs, immune globulin or blood products, and live virus vaccines.^{1,7}

9. Have you had (or are you a candidate for) your spleen removed, or do you have sickle cell anemia? [Hib, LAIV, PCV13, PPSV23, MCV4, MenB]

Patients with anatomic or functional asplenia (i.e. sickle-cell disease) are at an increased risk of certain vaccine preventable diseases to include Haemophilus influenzae type b, meningococcal, and pneumococcal disease. LAIV is not recommended for people with anatomic or functional asplenia. Hib, PCV13, MCV4, and MenB vaccine should be given 14 days before splenectomy, if possible. Doses given during the 14 days prior to surgery can be counted as valid. Doses that cannot be given prior to surgery should be given as soon as the patient's condition has stabilized after surgery. For patients 2 years of age and up: the first dose of PPSV23 should be administered 8 weeks after the last dose of PCV13. A second dose of PPSV23 should be administered 5 years after the first dose. A third, final dose of PPSV23 should be administered after age 65 years, if both previous doses were before the age of 65.

10. Have you ever passed out (had vasovagal syncope) during or after a previous immunization or blood draw? [all vaccines]

Providers should be aware of the potential for syncope (fainting) associated with vaccination, particularly among adolescents. Appropriate measures should be taken to prevent syncope, and to readily respond to the patient who feels faint. Observe all patients for 15 minutes after vaccination for signs and symptoms that precede syncope, such as weakness, dizziness, sweatiness, and pallor. For patients prone to syncope, make sure they are either seated or lying down at the time of vaccination. (If the patient is seated during vaccination, the immunizer should be seated as well, to minimize the risk of SIRVA). If a patient becomes pre-syncope, have them lie flat or sit with head between knees for several minutes; loosen any tight clothing and maintain an open airway; apply cool, damp cloths to the patient's face and neck. Observe the patient until symptoms completely resolve.

11. Have you received any vaccinations in the past 4 weeks? [LAIV, MMR, SPV, VAR, YF-Vax, ZVL]

Patients who were given either LAIV, SPV, or an injectable live virus vaccine should wait 28 days before receiving another live vaccine. Inactivated vaccines may be given at the same time or at any spacing interval.

12. Are you pregnant, or is there a chance you could become pregnant during the next month? [Adenovirus, HPV, IPV, MMR, LAIV, VAR, SPV, Ty21a, possibly YF-Vax, ZVL]

Live virus vaccines are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt.^{6,9} On theoretical grounds, HPV and IPV should not be given during pregnancy; however, IPV may be given if risk of exposure is imminent (e.g., travel to endemic areas). Inactivated influenza vaccine and Tdap are both recommended during pregnancy. Both vaccines may be given at any time during pregnancy, but the preferred time for Tdap administration is at 27-36 weeks gestation.¹⁰

1. ACIP General Best Practice Guidelines for Immunization: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf.
2. Latex in Vaccine Packaging: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latexable.pdf.
3. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/exipient-table-2.pdf.
4. Prevention and control of seasonal influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices. www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html.
5. Measles, mumps, and rubella-vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. MMWR 1998, 47(RR-8).
6. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. MMWR 2007, 56(RR-4).

7. Rubin L.G., Levin M.J., Ljungman P. (2014) IDSA Clinical practice guideline for vaccination of the immunocompromised host. *Clinical Infectious Diseases*, 58(3), 309–318
8. Tomblyn M, Einsele H, et al. 2009. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. *Biology of Blood and Marrow Transplant* 15:1143-1238.
9. Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. MMWR 2001; 50(49).
10. Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) in pregnant women: ACIP. MMWR 2012 62(07):131-135.

Vaccine Abbreviations:

- Hib: *Haemophilus influenza* type b
- HPV: human papillomavirus
- IIV: inactivated influenza
- IPV: inactivated poliovirus
- LAIV: live attenuated influenza
- MCV4: meningococcal conjugate, quadrivalent, serogroups A, C, W, Y
- MenB: meningococcal serogroup B
- MMR: measles, mumps, rubella
- PPSV23: pneumococcal polysaccharide (23-valent)
- RIV: recombinant influenza
- SIRVA: shoulder injury related to vaccine administration
- SPV: vaccinia (smallpox)
- Td: tetanus/diphtheria toxoids
- Tdap: tetanus toxoid, reduced diphtheria toxoid, acellular pertussis
- Ty21a: oral typhoid
- VAR: varicella
- YF-Vax: yellow fever
- ZVL: zoster vaccine live

INITIAL ENTRY TUBERCULOSIS (TB) RISK ASSESSMENT TOOL

For use of this form see, MEDCOM Reg 40-64, the proponent agency is MCPO-SA

INITIAL ENTRY Tuberculosis (TB) Risk Assessment Tool		REVIEWER INSTRUCTION
1. Have you ever had face-to-face contact with someone who was sick with tuberculosis (TB)?	☐ Yes ☐ No	
2. Were you born outside the United States? If yes, list country: _____	☐ Yes ☐ No	
3. Did you ever live with a family member that was born outside the United States? If yes, list country: _____	☐ Yes ☐ No	
4. Have you ever had a positive TB test, prior diagnosis of TB, or prior treatment for TB?	☐ Yes ☐ No	
If "NO" answers = low risk → STOP. Any "YES" answers = increase risk → Go to question #5		If all "NO" responses, Then do not test
5. Do you have any of the following symptoms of tuberculosis? Cough > 2 weeks, fever > 2 weeks, drenching night sweats, or unplanned weight loss?	☐ Yes ☐ No	
If "YES" → STOP. Any "NO" → Go to question #6		If "YES" then refer immediately to provider for evaluation of TB disease.
6. Do you have documentation of previous TB treatment with you today?	☐ Yes ☐ No <u>STOP.</u>	
Reviewer comments		If "YES" → Do NOT test. Document exemption in MEDPROS If "NO" → Test for TB. Note: If "Yes" response only to Question 2 or 3 above, testing is only required if the country is Listed on the reverse side.
PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last-first-middle; DOB; SSN; date; hospital or medical facility) NAME: DOB: DoD ID #: DATE:	REVIEWER NAME	REVIEWER SIGNATURE

The following countries, if documented on the TB Risk Assessment Tool, indicate need for patient to be tested:

Afghanistan	Egypt	Malaysia	Senegal
Algeria	El Salvador	Maldives	Serbia
Angola	Equatorial Guinea	Mali	Serbia & Montenegro
Anguilla	Eritrea	Marshall Islands	Seychelles
Argentina	Estonia	Mauritania	Sierra Leone
Armenia	Ethiopia	Mauritius	Singapore
Azerbaijan	Fiji	Micronesia – Fed States	Solomon Islands
Bahrain	French Polynesia	Moldova	Somalia
Bangladesh	Gabon	Mongolia	South Africa
Belarus	Gambia	Montenegro	Sri Lanka
Belize	Georgia	Montserrat	Sudan
Benin	Ghana	Morocco	Suriname
Bhutan	Guam	Mozambique	Swaziland
Bolivia	Guatemala	Myanmar	Syrian Arab Republic
Bosnia & Herzegovina	Guinea	N. Mariana Islands	Tajikistan
Botswana	Guinea – Bissau	Namibia	Tanzania-UR
Brazil	Guyana	Nauru	Thailand
British Virgin Islands	Haiti	Nepal	Timor-Leste
Brunei Darussalam	Honduras	New Caledonia	Togo
Bulgaria	India	Nicaragua	Tonga
Burkina Faso	Indonesia	Niger	Trinidad & Tobago
Burundi	Iran	Nigeria	Tunisia
Cambodia	Iraq	Pakistan	Turkey
Cameroon	Japan	Palau	Turkmenistan
Cape Verde	Kazakhstan	Panama	Turks & Caicos Islands
Central African Republic	Kenya	Papua New Guinea	Tuvalu
Chad	Kiribati	Paraguay	Uganda
China	Korea – DR	Peru	Ukraine
China, Hong Kong SAR	Korea – Rep of	Philippines	Uruguay
China, Macao SAR	Kuwait	Poland	Uzbekistan
Colombia	Kyrgyzstan	Portugal	Vanuatu
Comoros	Lao PDR	Qatar	Venezuela
Congo	Latvia	Romania	Viet Nam
Congo – DR	Lesotho	Russian Federation	Wallis & Futuna Islands
Cook Islands	Liberia	Rwanda	West Bank & Gaza Strip
Cote d'Ivoire	Libya	St. Vincent & Grenadines	Yemen
Croatia	Lithuania	Samoa	Zambia
Djibouti	Macedonia	Sao Tome & Principe	Zimbabwe
Dominican Republic	Madagascar	Saudi Arabia	
Ecuador	Malawi		