JOB CORPS IMMUNIZATION RECORD

Name _____ Center _____ DOB _____ DOE _____ ID Number _____

Before administering any vaccines, give copies of all pertinent Vaccine Information Statements (VISs) to students 18 or older, or mail to minor students' parent or legal representative.

Vaccine		Date Given (m/d/y)	Vaccine Site*	Vaccine			Vaccine Information Statement (VIS)		Vaccinator Signature
				Mfr.	Lot #	Exp. Date	Publication Date on VIS	Date Given	
REQUIRED IMMUNIZATIONS									
Tetanus-Diphtheria Toxoid-Adult (Td) *or*									
Tetanus-diphtheria-acellular pertussis (Tdap)									
Inactivated Poliovirus Vaccine (IPV) – age <18									
Measles/Mumps/Rubella (MMR)	1								
	2								
Hepatitis B Vaccine (HBV) Only required for HOT Students	1								
	2								
	3								

REACTIONS (use reverse as needed):

*RA (right arm), LA (left arm), RT (right thigh), LT (left thigh).

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RECOMMENDED IMMUNIZATIONS									
COVID-19	1								
	2								
	3								
Hepatitis A (HAV)	1								
	2								
Human papillomavirus vaccine (HPV4) or (HPV9)	1								
	2								
	3								
Influenza vaccine, inactivated (IIV)	1st yr								
	2nd yr								
Influenza vaccine, live attenuated (LAIV4)	1st yr								
	2nd yr								

REACTIONS (use reverse as needed):

*RA (right arm), LA (left arm), RT (right thigh), LT (left thigh), or IN (intranasal).

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RECOMMENDED IMMUNIZATIONS (continued)									
Meningococcal ACWY	1								
	2								
Meningococcal B	1								
	2								
	3								
Varicella	1								
	2								
Others:									

REACTIONS (use reverse as needed):

*RA (right arm), LA (left arm), RT (right thigh), LT (left thigh), or IN (intranasal).

TUBERCULIN TESTING

Name _____ Center _____

DOB _____ DOE _____ ID Number _____

Has student ever had:
1. Positive PPD skin test _____ Date (Month/Year)
2. IGRA blood test: _____ Date/Result (+/-)
3. Chest x-ray: _____ Date/Result (+/-)
4. Treatment for latent TB: _____ Date/Duration (Months)

Tuberculin skin test (PPD)

Date Given	Manufacturer Lot Number Expiration Date	Dose/Strength Route Injection Site	Initials	Date Read	Initials	Induration in Millimeters
						MM
						MM

Note: Read reaction in 48-72 hours after injection
Measure only induration, not erythema
Record results in millimeters
Record as positive or negative per CDC guidelines
Interpret without regard to history of BCG vaccination

CLASSIFYING THE TUBERCULIN REACTION	
≥ 5mm is positive in:	• Recent contacts of a TB case • Students with fibrotic changes on chest x-ray consistent with old TB • HIV-infected students • Organ transplant recipients • Immunosuppressed students (e.g., taking the equivalent of > 15 mg/day of prednisone for > one month or taking TNF-α antagonists)
≥ 10mm is positive in:	• Recent immigrants (< 5 years) from high prevalence countries • Injection drug users • Residents of homeless centers
≥ 15mm is positive in:	• No known risk factors for TB

Note that induration, not erythema, is measured in mm. Tuberculin skin test results should be interpreted without regard to a prior history of BCG vaccination.

Date of IGRA blood test (if performed) and results: _____

Date of chest x-ray and results: _____

CHEMOPROPHYLAXIS FOR LATENT TUBERCULOSIS

Name _____ Center _____

DOB _____ DOE _____ ID Number _____

Pharmacologic management of latent tuberculosis infection includes:

Isoniazid & Rifapentine* (3HP) INH 15 mg/kg (max 900 mg) & RPT (rifapentine) ≥50 kg-900 mg (max 900 mg)	3 months	Once per week** with direct observation therapy (DOT) or self-administered therapy (SAT)	Preferred regimen with strong recommendation. Treatment recommended for individuals: • ≥2 years of age • In persons who have HIV infection, including AIDS*** Not recommended for individuals who are: • pregnant or expect to become pregnant within 12 weeks**** • presumed infected with INH or RIF-resistant TB
Rifampin RIF 10 mg/kg (max 600 mg)	4 months	Daily	Preferred regimen with strong recommendation. Pregnancy Category C

Three additional regimens have conditional recommendations and require daily dosing for 3, 6, or 9 months.

* Prescribing providers or pharmacists who are unfamiliar with rifampin and rifapentine might confuse the two drugs. They are not interchangeable, and caution should be taken to ensure that patients receive the correct medication for the intended regimen.

** Health care providers can choose the mode of administration as either DOT or SAT. Given ease of DOT in Job Corps setting, this will likely be the preferred option for centers.

*** 3HP is the recommended treatment of LTBI in persons with HIV infection including AIDS, who are otherwise healthy and not taking antiretroviral medications or are taking antiretroviral medications with acceptable drug-drug interactions with rifampin

**** In pregnancy, consider delaying treatment until after delivery unless high risk for progression to active disease (recent TB exposure, HIV infected)

Which regimen was initiated? ☐ Isoniazid & Rifapentine once per week for 12 weeks
☐ Rifampin once daily for 4 months

Symptoms (e.g., fever/chills, fatigue, weakness, malaise, anorexia, stomach pain, nausea/vomiting, diarrhea, tingling/numbness fingers, dark urine/pale stools, yellowness of skin/eyes, rash/itching. Note below with the date of onset.)

_____

_____

Additional comments or tests ordered/results:

Date _____

Date _____

Date record closed _____

Reason for termination of chemoprophylaxis (check all that apply):

- ☐ Completed treatment
- ☐ Non-compliant
- ☐ Toxicity
- ☐ AWOL
- ☐ Separation
- ☐ Other

Moved/Forwarding Address: _____

_____

Date student started on preventive treatment: _____

Date student completed preventive treatment: _____

Reason student declined preventive treatment: _____

Student signature: _____ **Date:** _____