

Standing Delegation Orders - Pediatrics

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Pediatric Support Staff

GENERAL DUTIES and Delegation Orders

- Monitor computer desktop for patients that have checked in.
- Greet family; confirm patient's name and date of birth; then assign patient to exam room with encounter form in hand, and confirm the nature of the current visit in a timely manner.
- Begin computer work –
 1. Open new encounter and select appropriate template for current visit.
 2. Check status of primary consent needs to be current within the last 12 months and include changes in custody or caregiver arrangements for the child.
 3. Confirm/update/ and modify medical, surgical and social history noting any changes that have occurred since child was last seen in the clinic.
 4. Identify health care need(s) for visit depending on age of the child
 - Do they need immunizations? – utilize immunization schedule to verify; then offer vaccines as required.
 - If parent refuses vaccines – utilize the “Refusal To Vaccinate” form; be sure to check off all recommended vaccines before parent signs the form; offer pertinent VIS forms to parent.
 - Do they need blood work? – review previous office visit notes.
 - Did they have a Well Child visit scheduled but are currently ill - If yes, then utilize age-appropriate well-child visit template.
 - Is the child present for a sick visit but behind on immunizations? – Inform parent to schedule a follow up nurse visit for catch-up immunizations when illness has resolved.

Schedule for Regular Well Child Exams

1. 1st year – 3-7 days, 2 weeks, 2 mo, 4mo, 6mo, 9mo, and 12months
2. 2nd year – 15 mo, 18mo and 24months

3. 3rd year – 30mo and 36 months
4. Yearly after 3 years of age

Routine Task for all Well Child Exams

1. Vital signs
 - a. **Weight** – Use baby scales (either laying down or sitting up) until able to readily stand alone, about 2 years of age. All children up to the age of 12 months should be weighed naked.
 - b. **Length** – Until 2 years (laying down on table) – then height is appropriate, without shoes from 2 years and up.
 - c. **Head Circumference** – Until 2 years of age – widest part of the head, just above ears and eyebrows.
 - d. **Temperature** – rectal for newborns (less than 1 month) then temporal
 - e. **Pulse**
 - f. **Respiration**
 - g. **Pulse Oximetry** – On *all* patients 12 months or younger; AND any patient with cough and/or wheeze associated with fever by history; has a history of asthma, reactive airways disease or bronchiolitis.
 - h. **Blood Pressure** – At 3 years of age – use appropriate cuff size for child’s arm.
 - i. **Waist Circumference** – beginning at 2 years of age.
2. Obtain **Vision Screen**, even if patient uses corrective lenses on children beginning at 3 years of age during all well child visits.
 - a. Right eye
 - b. Left eye
 - c. Both eyes
3. **Hearing Screens** – test at 4,000 2,000 and 1,000 Hz at 25 DB on children from ages 4,5,6,8,10 and 15 years
4. **Conduct the Required Autism Screen** – at 18 and 24 months – using the Modified Checklist for Autism in toddlers (M-CHAT) screening tool.
5. **Utilize the Tuberculosis (TB) Screening Questionnaire** – for annual TB screening beginning at 12 months of age.
6. **Conduct Mandatory Developmental Screen using center-approved ASQ screening tool** - at ages 9 months, 18 months, 2, 3 and 4 years of age.
7. **Immunizations** – In the 1st 2 years of life, these are offered at the 2, 4, 6, 12 and 15- 18 months well child visits utilizing the current CDC Recommended Immunization Schedule for persons aged 0 to 18 years.

- a. The scheduled 9 month and 18month well child check-up visits are for “catch-up” immunizations when necessary, and to do more specific developmental assessments.
- b. Obtain records for any immunizations done elsewhere and enter dates in the EMR to maintain current records for the child.
- c. After 2 years of age immunizations are more sporadic;
 1. At age 4 – before school starts
 2. At age 11 – offer HPV, Tdap and MCV4 vaccines
 3. At 16 years – offer the MCV4 booster and the MenB vaccine series (if so desired)
 4. After age 6 months – offer the influenza vaccine on an annual basis

If no shot record is available – Indicate that you have requested copy from parent/ guardian in the “pop-up” and in the plan portion of the EMR for that encounter.

Attempt to locate a current copy of child’s record using the “ImmTrac” Texas Immunization Registry system.

If the child is not following the typical Immunization pattern – Consult the “Catch- up” Immunization Schedule for persons 4 months Through 18 years, Make note in the EMR, or create a separate encounter with the anticipated plan to “Catch- up” the child’s immunizations.

8. Laboratory Tests

- a. **Newborn Screens (NBS)** – also known as PKU
 1. 1st blood screen is done while infant is still in hospital.
 2. A 2nd blood test should be done when the infant is 7 days old or older.
 3. NBS for infants/children born anywhere in the state of Texas after 2007 can be obtained on the state website.
 4. For new children not meeting #3 – obtain a Hemoglobin Electrophoresis at time of 1st visit.
- b. **Hemoglobin (Hgb) and lead**
 1. Patients need hemoglobin blood test drawn at 12months of age.
 2. Patients must have lead test at 12months and 24months of age.
- c. **Dyslipidemia**

In addition to the current risk based screening for patients 24months to 20 years of age, all patients must have a lipid panel blood test between the ages of 9-11 years and again between 18-20 years, regardless of risk.

Pediatric Support Staff

Sick Children – Office Visit

Sick Children –

1. Obtain temperature, pulse rate, respiratory rate, waist circumference, blood pressure, height and weight without heavy outer clothing/shoes.
2. Obtain **detailed** information regarding current problems and record in the computer/on encounter form – Helpful information includes –
 - a. Chief complaint
 - b. Length of time of current illness,
 - c. If injured or skin rash, document location of lesion such as face or leg; left or right.
 - d. Any treatment that was attempted.
 - e. Any additional concerns of parents.
 - f. Anyone else at home sick(sick contacts)
3. Consider – Rapid Strep or Flu test if symptoms indicate.
 - a. Flu symptoms i.e. fever (documented > 101 at home), body ache, cough, headache during the flu season
 - b. Rapid Strep test if documented fever (>101) AND other symptoms such as a sore throat, abdominal pain, vomiting etc.
4. Consult immediately with provider if:
 - a. Child's temperature is elevated =>102
 - b. Evidence of respiratory difficulty or audible wheezing.

STANDING ORDERS for Nursing/ Laboratory Staff

Emergent/ Urgent Situations:

1. If a patient presents with a **diastolic blood pressure of 100** or greater and/or a **systolic of 180** or greater, the clinic staff is to notify the attending provider for guidance/ orders.
2. If a **child presents with a temperature** of 102.4F or greater, support staff may give Ibuprofen or Acetaminophen appropriate for the age and weight in accordance with FDA approved dosages; this may be administered orally or rectally.
3. **Patients with respiratory distress** and/or known asthma diagnosis may have pulse oximetry performed and a rescue short-acting bronchodilator such as Albuterol or Xopenex treatment administered while waiting to see a medical provider. Provider must be immediately notified.
4. Patients complaining of **chest pain** may have an immediate EKG, and the provider immediately notified.

Special Instructions:

1. Patients with open wounds or lacerations may have these cleaned and the clinic support staff may set up for suturing if indicated.
2. Prescription renewals for chronic disease medications excluding narcotics, anxiolytics, and anti-psychotic meds may be authorized by designated clinic support staff in accordance with approved refill guidelines.

Immunizations/ Vaccinations:

1. During well child/infant visits, clinic support staff may follow approved guidelines (CDC Recommended Immunization Schedules for Persons Aged 0 through 18 Years) for required immunizations without consulting the provider.
2. Clinic support staff may administer the annual tuberculosis screening questionnaire if due and/or when appropriate.
3. The TB skin test should be administered by support staff if ordered by the medical provider.

Laboratory Testing/ Preventive Health Screenings:

1. All patients who present with urinary symptoms such as pain with urination, bloody urine, and pelvic pain, vaginal or penile discharge may have a urine sample obtained for urinalysis.
2. All patients 13 – 64 years of age must undergo routine HIV screening once a year (or more frequently if requested by the patient) utilizing the center-approved HIV blood test via the opt-out screening method. Patient's refusal of test should be documented in the medical record. The medical provider is responsible for delivering blood test results.
3. Patients with complaints of a sore throat in the setting of fever, may have a rapid strep test and/or a flu test (if during flu season).
4. Patients who present for a family planning/birth control visit and/or complaint of amenorrhea (absence of menses) should have a urine pregnancy test.
5. All patients who present for the first prenatal (OB) visit must have the following lab test: GC/Chlamydia; CBC/diff; ABO/Rh/Ab; HIV; Hepatitis B surface antigen; Syphilis (RPR or VDRL); urine culture.

6. GBS culturettes should be obtained in all OB patients at 35-37 weeks gestation or anytime thereafter if late prenatal care or missed appointments.
7. Patients who present for a physical that requires specific routine lab tests may have these tests obtained prior to being seen by the provider.
8. All patients 12 years and older must have depression screening conducted every 6 months using center-approved screening tools, unless they have an established diagnosis of depression and/or bipolar disorder.
9. Patients between 50 and 75 years of age who have not been screened for colorectal cancer via documented colonoscopy in the past 10 years; stool-DNA (Cologuard) within the past 1 – 3 years, or fecal occult blood test (FOBT and FIT) in the past 12 months must be offered a home colorectal cancer screening kit with instructions regarding use unless medical provider/PCP states otherwise.
10. Women age 21-64 years should have a Pap smear every 3 years; those patients age 30-64 years have the option of co-testing with Pap smear and HPV testing every 5 years (if the test is available) unless medical provider/PCP indicates otherwise.
11. Women age 50-74 years of age should be referred for a screening mammogram every 2 years unless provider/PCP states otherwise.

Chronic Disease Management:

1. If a patient has an established diagnosis of diabetes, the support staff or lab personnel may obtain the following:

HbA1c every 3 months unless the medical provider states otherwise.
Fasting lipid profile every three to four months if previous LDL >70mg%; otherwise once a year.
Comprehensive metabolic panel every three to four months.
Annual spot urine micro albumin-creatinine ratio if no evidence of medical documentation indicative of nephropathy
Annual dilated eye exam by optometrist or ophthalmologist

2. If a patient has an established diagnosis of cardio vascular disease (CVD), the support staff may obtain the following:

Fasting lipids every three months for CAD, dyslipidemia if most recent LDL > 100mg%
Fasting lipids may be obtained every four to six months for patients with Hypertension *only*.
Comprehensive metabolic panel may be obtained every four to six months.
Annual electrocardiogram (EKG)

Signature: _____

Annette Okpeki, M.D., Chief Medical Officer

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Revised Feb. 8, 2017; Revised May 18, 2018; Revised June 2019

Managing Medical Emergencies

SUBJECT: Medical Emergencies in the Clinic

PURPOSE: To establish guidelines for staff to follow during medical emergencies.

ACCOUNTABILITY: This guideline applies to all licensed medical staff. **The highest level of licensed medical personnel should take the lead in directing clinical management in all medical emergencies.** All medical staff must maintain a current cardio-pulmonary resuscitation (CPR) card.

EMERGENCY SUPPLIES: The following supplies shall be present in all clinics as listed below:

1. Diphenhydramine injectable 50mg/mL vial (1); 25mg tablets/capsules (1 box/container)
2. Aqueous Epinephrine 1:1000 dilution
3. Nitro stat (Nitroglycerin) 0.4mg (1/150mg) Sublingual 100 tablets (1 bottle)
4. Chewable baby aspirin (ASA 81mg tablets)
5. Glucose tablets
6. Adult and Pediatric Ambu Bags (1 each)
7. 3cc syringes (x4)
8. Disposable, non-sterile gloves 2 pairs (1 medium, 1 large)
9. Portable oxygen tanks with 100% re-breather masks
10. Adult and Pediatric oral airway
11. AED

PROCEDURE: **When the determination has been made that an emergent medical event is occurring, the local community emergency system must be activated (by phone) immediately by dialing 911.**

I. Assessment

- Assess the nature of the medical emergency. Is it a vasovagal reaction, anaphylaxis, syncope, cardiac arrest, shock, hemorrhage or respiratory difficulties?

II. Intervention

- **Activate the emergency medical system** for all emergencies; the phone number to dial is 911. Bring Emergency Kit and Oxygen to the room where the emergency is occurring.
- **Initiate CPR** if indicated (Chest compressions, Airway, Breathing)
- **Altered Level of Consciousness**
Check patient to determine if injured before moving patient. If no, place flat on back; ensure airway patency; use rescue breathing as needed.
- **Hemorrhage**
Apply pressure to bleeding sites.
Monitor vital signs.
Have patient lie down and elevate lower extremities if blood pressure is low.

- **Seizures**
Have patient lie down on their left side to allow for drainage of secretions.
Monitor airway patency. Use airway if needed.
Monitor vital signs
- **Anaphylaxis**
Place patient flat on back unless patient is having difficulty breathing; elevate legs slightly above the level of the heart if blood pressure is low.
Maintain patient airway; perform CPR if necessary.
Give IM Benadryl standard dose 1-2mg/kg up to 50mg (maximum single dose in adolescents and adults); or 30mg (maximum single dose in children)
Notify medical provider if patient is experiencing respiratory difficulty
Give IM Epinephrine 1:1000 (1mg/mL) if there is airway obstruction and the client is having difficulty breathing. Adult dosing: 0.01mL/kg/dose (0.3mL to 0.5mL to maximum single dose of 0.5mL) Pediatric dosing: 0.01mg/kg body weight, up to 0.3mg maximum single dose in children and 0.5mg maximum single dose in adolescents.
If EMS has not arrived and patient remains symptomatic, may repeat dose of epinephrine every 5-15 minutes for up to 3 doses depending on patients response.

III. **EMS Arrival**

- Immediately turn all of the patients care over to the EMS staff
- Make a copy of all appropriate medical information from the medical record and give to EMS personnel.

IV. **Patient refuses medical Intervention**

- Explain possible risks and consequences of refusal.
- Explain benefits of intervention.
- Complete the "Refusal of Treatment" form.
- If the patient refuses to sign, document in the medical record that the patient left against medical advice (AMA) and refused to sign form.

V. **Documentation**

- Document medical facts regarding the event in the patient's medical record; keep notes concise and factual.
- Complete the "Incident Report" form in accordance with the Incident Reporting policy and procedure.

Updated 5/22/2019

Administration of Vaccines

I. Method used in developing and approving vaccine administration to Children.

The Wellness Pointe pediatric department follows the Recommended Immunization Schedules for persons aged 0 through 18 years approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians.

Recommendations for changes in the timing, scheduling or combinations of vaccines are made by the Centers for Disease Control and Prevention and the Texas Department of State Health Services.

II. Experience, Training, and/or Education requirements

All support staff administering vaccines shall possess the requisite experience, training, and/or education necessary to perform them in the judgment of the delegating provider, as evidenced of both on this order. Initial competency for giving vaccines to children shall be evaluated by the delegating provider and/or clinical coordinator, who is a Registered Nurse. Each non-licensed support staff is initially supervised exclusively for this task.

III. Circumstances for administration of vaccines in Pediatric Populations

- A. Each Pediatric staff member refers to the age-appropriate schedule for vaccine administration. Staff must confirm that vaccines are given in proper time intervals and in proper combinations.
- B. Recommendations for changes in timing, scheduling or combinations of vaccines are made from the Centers for Disease Control, American Academy of Pediatrics and the Texas Department of Health Services.
- C. Children who meet certain criteria are eligible to receive vaccines at no cost to the providers in order to maximize the number of children fully immunized against vaccine preventable diseases. (See Specifics of eligibility for Texas Vaccines for Children Program).

IV. *Specific requirements to be followed in vaccine administration*

- A. Pediatric support staff determines which vaccine/s the child/adolescent requires based on the chart listed above and the child's individual vaccine record. (See example of individual child's immunization record and the specifics of TVFC)
- B. Several vaccines are administered orally (Rotovirus) and therefore do not need to be injected into the skin.
- C. Several vaccines must be injected into the skin:
 - 1. The vaccine must be prepared according to the package instructions for mixing for the specific vaccine. Some vaccines must be used within 30 minutes of mixing.
 - 2. Some vaccines come in pre-filled syringes and simply need to have a needle added prior to administration.
 - 3. Some vaccines need to be combined or reconstituted prior to administration.
 - 4. Some vaccines come in vials of solution and simply need to be drawn up into a syringe prior to administration.
 - 5. The needle size is 22-25 gauge based on the age and size/weight of the infant/child and whether vaccine administered IM or SubQ.
 - 6. The needle length is based on age, size and whether the vaccine is administered IM or SubQ. Generally, for infants birth to 12 months of age, is 5/8 - 1 inch and over 12 months is 1 inch.
- D. Based on the age of the child, determine location desired to give the injection and whether additional assistance will be needed to secure the child during the procedure.

1. Parents are allowed and encouraged to assist in restraining the child for this procedure.
2. The preferred location is the *vastus lateralis* for infants and toddlers who are lacking adequate deltoid muscle mass.
3. For toddlers and older children either the *vastus lateralis* or the deltoid muscle can be used for injecting vaccines.



Pediatric

Standing Delegation
Orders
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- E. Specific steps to administer vaccines:
1. Support staff administering vaccines will wear gloves.
 2. Usually give oral vaccine first. Vaccine is given slowly allowing the infant time to swallow. For the intra-nasal vaccine follow special procedure for this vaccine. Stop if this is all that infant/child needs.
 3. To inject vaccines into the skin:
 - a. Prepare the skin for the injection using alcohol and 2x2's,
 - b. Pierce the skin with the needle,
 - c. Advance needle until hub is near the skin,
 - d. Then inject the vaccine.
 - e. Withdraw the needle and apply pressure to the area using the 2x2 and
 - f. Secure fresh clean band-aid to the area.
 4. All sharps materials are disposed of in appropriate bio-hazardous containers located in every exam room and in the vaccine preparation area.
- F. All parents and caregivers of children receiving vaccinations within the clinic will receive a copy of the appropriate Vaccine Information Statement (VIS) in the appropriate language. The staff member

administering the vaccine will review the document verbally with parents and caregivers. Included in this group of documents are instructions for parents about medications used for fever reduction after vaccine administration.

- G. Each vaccine is logged out of the storage area on a log sheet of all vaccines administered in a given time period. At Wellness Pointe pediatrics this log is typically changed daily. This log includes information specific to the child receiving the immunization as well as his eligibility for Texas Vaccines for Children (TVFC) program.
- H. Information concerning the specific vaccine is documented in the child's chart as part of Center's Electronic Medical Records (EMR) system according to Center policy. This information includes: the lot number of the vial administered, the location given, the support person administering the vaccine and the VIS date. A copy of the individual immunization record is given to the parents/caregivers that accompany the child each time additional vaccines are given and at well child checks.

V. *Method for initial and continuing competency evaluation*

- A. Initial competency for giving vaccines to children shall be evaluated by the delegating provider and clinical coordinator, who is a registered nurse. Each non licensed support staff is initially supervised exclusively for this task during the first 90 days of employment.
- B. Continuing competency shall be evaluated no less than annually by the delegating provider and/or clinical coordinator by means of the annual clinical performance review.
- C. Vaccines in storage are physically counted daily and recorded on a computer spreadsheet. This count is justified with the log recording of vaccines administered. Discrepancies are noted in individual charts so that corrections can be made when necessary. Reports are submitted to the Texas Department of Health Services monthly. Audits of individual records are conducted by the Texas Department of Health Services annually to ensure accuracy and completeness.

VI. *Scope of supervision required for vaccine administration*

All staff administering vaccines shall possess the requisite experience, training and/or education necessary to perform them in the judgment of the delegating provider.

VII. *Specialized circumstances requiring immediate communication with physician*

A. Adverse Reaction

In the event that a child suffers an adverse reaction to an immunization, the staff member will immediately notify the provider in charge, the medical Director, and the Executive Director. A true vaccine reaction requires documentation submitted to the State Health Department.

B. Parental Decisions

Parents have the right to decline to vaccinate their children, but support staff should discuss this with the provider in charge. Parents may also request that vaccines be spaced out so that fewer different vaccines are given at each visit. Wellness Pointe has documents that parents must sign to confirm the declination/refusal of vaccines.

VIII. *Limitations of practice setting*

Vaccines for patients aged 0 to 18 years are given according to the schedule for vaccines only when provided evidence of prior vaccines given and the child has an adult present to consent to the administration of vaccines.

IX. *Patient record-keeping requirements*

Vaccine administration, including name and title of administering support staff, and any variations from expected outcomes shall be documented in the center's Electronic Medical Records system according to Center policy.

Requirements Texas Vaccines for Children

The Texas Vaccines for Children (TVFC) program has participated in the Federal Vaccines for Children Program (VFC) since its beginning in 1994. The program was initiated by the Omnibus Budget Reconciliation Act of 1993, which guaranteed vaccines would be available at no cost to providers, in order to immunize children (aged 0 to 18 years) who meet the eligibility requirements.

A. Provider Eligibility Requirements include:

1. Providers must be one of the following
 - a. Physician (Medical Doctor or Doctor of Osteopathy)
 - b. Nurse Practitioner
 - c. Certified Nurse Midwife
 - d. Physician's Assistant
2. All other health care providers must enroll under the standing delegation order of a physician including:
 - a. Pharmacists
 - b. Nurses (Registered or Licensed Vocational nurses)
 - c. Medical Assistants
 - d. Nurse Assistants
 - e. Emergency Medical Technicians

B. Patient Eligibility Requirements include:

1. Any child who meets just one or the eligibility criteria listed below and who is 18 years of age or younger, qualifies for TVFC vaccines
 - a. Enrolled in Medicaid, or
 - b. Does not have health insurance, or
 - c. Is an American Indian (Native American), or
 - d. Is an Alaskan Native, or
 - e. Underinsured (Has health insurance that does not pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage), or
 - f. Enrolled in CHIP
2. Providers must complete the proper Eligibility Screening Form (C-10) for the child to be qualified. Forms need to be revised if the child's status changes, and kept for 3 years.
3. Immigration status does not affect a client's eligibility for the TVFC program.

Immunizations for Children

Vaccines ~

Hepatitis B – Hep B

Rotovirus – Roto

Diphtheria, Tetanus, Pertusis – Dtap

Haemophilus influenzae type b - HIB

Pneumophilus - Prevnar (PCV)

Inactivated Poliovirus - IPV

Influenza - Flu

Measles, Mumps, Rubella - MMR

Varicella - (chicken pox)

Hepatitis A - Hep A

Meningococcal - MCV

Human Papillomavirus - HPV - (Gardasil)

Combination vaccines are available -

- **Pentacel** contains Dtap, IPV, and HIB
- **Pediarix** contains Dtap, IPV, and Hep B
- **MMR** contains Measles, Mumps, and Rubella
- **Kinrix** contains Dtap and IPV
- **ProQuad** contains Measles, Mumps, Rubella and Varicella (MMRV)

2mo - Pentacel - (Dtap, IPV, HIB) and Hepatitis B;/ or Pediarix - (Dtap, IPV, Hep B) and Hib; Prevnar; Roto

4mo - Pentacel - (Dtap, IPV, HIB); / or Pediarix - (Dtap, IPV, Hep B); Hib; Prevnar; Roto

6mo - Pentacel - (Dtap, IPV, HIB) and Hepatitis B;/ or Pediarix - (Dtap, IPV, Hep B) and Hib; Prevnar; Roto

12mo - MMR; Varicella; Hep A; Prevnar (PCV) or ProQuad; Hep A; Prevnar (PCV)

15mo - Pentacel - (Dtap, IPV, HIB)

24mo - Hep A

4 Yr. - Kinrix (Dtap, IPV); MMR; Varicella or Kinrix (Dtap, IPV); ProQuad

Influenza - after 6 months - Children need 2 doses to start 30 days apart, then annually.

A Catch-up Immunization Schedule for Persons aged 4 months through 18 years who start late or who are more than 1 month behind is available from the Department of Health and Human Services - Centers for Disease Control and Prevention.

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES
2019

Vaccines in the Child and Adolescent Immunization Schedule*

Vaccines	Abbreviations	Trade names
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel Infanrix
Diphtheria, tetanus vaccine	DT	No Trade Name
<i>Haemophilus influenzae</i> type b vaccine	Hib (PRP-T) Hib (PRP-OMP)	ActHIB Hiberix PedvaxHIB
Hepatitis A vaccine	HepA	Havrix Vaqta
Hepatitis B vaccine	HepB	Engerix-B Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated)	IIV	Multiple
Influenza vaccine (live, attenuated)	LAIV	FluMist
Measles, mumps, and rubella vaccine	MMR	M-M-R II
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM	Menactra Menveo
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero Trumenba
Pneumococcal 13-valent conjugate vaccine	PCV13	Prenvar 13
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax
Poliovirus vaccine (inactivated)	IPV	IPOL
Rotavirus vaccine	RV1 RV5	Rotarix RotaTeq
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel Boostrix
Tetanus and diphtheria vaccine	Td	Tenivac Td vaccine
Varicella vaccine	VAR	Varivax
Combination Vaccines (Use combination vaccines instead of separate injections when appropriate)		
DTaP, hepatitis B, and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix
DTaP, inactivated poliovirus, and <i>Haemophilus influenzae</i> type b vaccine	DTaP-IPV/Hib	Pentacel
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix Quadacel
Measles, mumps, rubella, and varicella vaccines	MMRV	ProQuad

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the child/adolescent immunization schedule

- 1** Determine recommended vaccine by age (**Table 1**)
- 2** Determine recommended interval for catch-up vaccination (**Table 2**)
- 3** Assess need for additional recommended vaccines by medical condition and other indications (**Table 3**)
- 4** Review vaccine types, frequencies, intervals, and considerations for special situations (**Notes**)

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), and American College of Obstetricians and Gynecologists (www.acog.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or (800-822-7967)



Download the CDC Vaccine Schedules App for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information

- Complete ACIP recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- General Best Practice Guidelines for Immunization: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Outbreak information (including case identification and outbreak response), see Manual for the Surveillance of Vaccine-Preventable Diseases: www.cdc.gov/vaccines/pubs/surv-manual



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

Table 1

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger United States, 2019

These recommendations must be read with the Notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Table 1. To determine minimum intervals between doses, see the catch-up schedule (Table 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16 yrs	17-18 yrs	
Hepatitis B (HepB)	1 st dose	2 nd dose			←----- 3 rd dose -----→													
Rotavirus (RV) RV1 (2-dose series); RV5 (3-dose series)			1 st dose	2 nd dose	See Notes													
Diphtheria, tetanus, & acellular pertussis (DTaP: <7 yrs)			1 st dose	2 nd dose	3 rd dose			←---- 4 th dose ----→				5 th dose						
Haemophilus influenzae type b (Hib)			1 st dose	2 nd dose	See Notes		←-- 3 rd or 4 th dose, See Notes --→											
Pneumococcal conjugate (PCV13)			1 st dose	2 nd dose	3 rd dose		←---- 4 th dose ----→											
Inactivated poliovirus (IPV: <18 yrs)			1 st dose	2 nd dose	←----- 3 rd dose -----→							4 th dose						
Influenza (IIV)					Annual vaccination 1 or 2 doses								Annual vaccination 1 dose only					
or													or					
Influenza (LAIV)												Annual vaccination 1 or 2 doses	Annual vaccination 1 dose only					
Measles, mumps, rubella (MMR)					See Notes	←---- 1 st dose ----→						2 nd dose						
Varicella (VAR)						←---- 1 st dose ----→						2 nd dose						
Hepatitis A (HepA)					See Notes	2-dose series, See Notes												
Meningococcal (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)			See Notes											1 st dose		2 nd dose		
Tetanus, diphtheria, & acellular pertussis (Tdap: ≥7 yrs)																	Tdap	
Human papillomavirus (HPV)																	See Notes	
Meningococcal B																	See Notes	
Pneumococcal polysaccharide (PPSV23)																	See Notes	

■ Range of recommended ages for all children
 ■ Range of recommended ages for catch-up immunization
 ■ Range of recommended ages for certain high-risk groups
 ■ Range of recommended ages for non-high-risk groups that may receive vaccine, subject to individual clinical decision-making
 ■ No recommendation

Table 2

Catch-up immunization schedule for persons aged 4 months–18 years who start late or who are more than 1 month behind, United States, 2019

The figure 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. Always use this table in conjunction with Table 1 and the notes that follow.

Children age 4 months through 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	Birth	4 weeks	8 weeks <i>and</i> at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days	4 weeks	4 weeks Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis	6 weeks	4 weeks	4 weeks	6 months	6 months
<i>Haemophilus influenzae</i> type b	6 weeks	No further doses needed if first dose was administered at age 15 months or older. 4 weeks if first dose was administered before the 1 st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months.	No further doses needed if previous dose was administered at age 15 months or older. 4 weeks if current age is younger than 12 months <i>and</i> first dose was administered at younger than age 7 months, <i>and</i> at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. 8 weeks and age 12 through 59 months (as final dose) if current age is younger than 12 months <i>and</i> first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months <i>and</i> first dose was administered before the 1 st birthday, <i>and</i> second dose administered at younger than 15 months; OR if both doses were PRP-OMP (PedvaxHIB; Comvax) <i>and</i> were administered before the 1 st birthday.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1 st birthday.	
Pneumococcal conjugate	6 weeks	No further doses needed for healthy children if first dose was administered at age 24 months or older. 4 weeks if first dose administered before the 1 st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1 st birthday or after.	No further doses needed for healthy children if previous dose administered at age 24 months or older. 4 weeks if current age is younger than 12 months and previous dose given at <7 months old. 8 weeks (as final dose for healthy children) if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	4 weeks	4 weeks if current age is < 4 years. 6 months (as final dose) if current age is 4 years or older.	6 months (minimum age 4 years for final dose).	
Measles, mumps, rubella	12 months	4 weeks			
Varicella	12 months	3 months			
Hepatitis A	12 months	6 months			
Meningococcal	2 months MenACWY-CRM 9 months MenACWY-D	8 weeks	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal	Not Applicable (N/A)	8 weeks			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1 st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1 st birthday.	6 months if first dose of DTaP/DT was administered before the 1 st birthday.	
Human papillomavirus	9 years	Routine dosing intervals are recommended.			
Hepatitis A	N/A	6 months			
Hepatitis B	N/A	4 weeks	8 weeks <i>and</i> at least 16 weeks after first dose.		
Inactivated poliovirus	N/A	4 weeks	6 months A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	4 weeks			
Varicella	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

Table 3

**Recommended Child and Adolescent Immunization Schedule by Medical Indication
United States, 2019**

VACCINE	INDICATION									
	Pregnancy	Immunocompromised status (excluding HIV infection)	HIV infection CD4+ count ¹		Kidney failure, end-stage renal disease, on hemodialysis	Heart disease, chronic lung disease	CSF leaks/cochlear implants	Asplenia and persistent complement deficiencies	Chronic liver disease	Diabetes
			<15% and total CD4 cell count of <200/mm ³	≥15% and total CD4 cell count of ≥200/mm ³						
Hepatitis B	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Rotavirus	Yellow	Orange SCID ²	Orange	Orange	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Diphtheria, tetanus, & acellular pertussis (DTaP)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
<i>Haemophilus influenzae</i> type b	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Pneumococcal conjugate	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Inactivated poliovirus	Orange	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Influenza (IIV)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
or Influenza (LAIV)	Red	Red	Red	Red	Orange Asthma, wheezing: 2-4yrs ³	Red	Red	Red	Orange	Orange
Measles, mumps, rubella	Red	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Varicella	Red	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Hepatitis A	Purple	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Meningococcal ACWY	Purple	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Tetanus, diphtheria, & acellular pertussis (Tdap)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Human papillomavirus	Pink	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Meningococcal B	Orange	Purple	Purple	Purple	Purple	Purple	Purple	Yellow	Purple	Purple
Pneumococcal polysaccharide	Purple	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow

■ Vaccination according to the routine schedule recommended
 ■ Recommended for persons with an additional risk factor for which the vaccine would be indicated
 ■ Vaccination is recommended, and additional doses may be necessary based on medical condition. See Notes.
 ■ Contraindicated or use not recommended—vaccine should not be administered because of risk for serious adverse reaction
 ■ Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction
 ■ Delay vaccination until after pregnancy if vaccine indicated
 ■ No recommendation

1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization “Altered Immunocompetence” at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Table 4-1 (footnote D) at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

2 Severe Combined Immunodeficiency

3 LAIV contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months.

For vaccine recommendations for persons 19 years of age and older, see the Recommended Adult Immunization Schedule.

Additional information

- Consult relevant ACIP statements for detailed recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For information on contraindications and precautions for the use of a vaccine, consult the General Best Practice Guidelines for Immunization and relevant ACIP statements at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥ 4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as “through.”
- Vaccine doses administered ≤ 4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥ 5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccine requirements and recommendations is available at wwwnc.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases*. 31st ed. Itasca, IL: American Academy of Pediatrics; 2018:67–111).
- For information regarding vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

- 5-dose series at 2, 4, 6, 15–18 months, 4–6 years
 - **Prospectively:** Dose 4 may be given as early as age 12 months if at least 6 months have elapsed since dose 3.
 - **Retrospectively:** A 4th dose that was inadvertently given as early as 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older.
- For other catch-up guidance, see Table 2.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, 12–15 months
- **PedvaxHIB:** 3-dose series at 2, 4, 12–15 months

Catch-up vaccination

- **Dose 1 at 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before 12 months and dose 2 before 15 months:** Administer dose 3 (final dose) 8 weeks after dose 2.
- **2 doses of PedvaxHIB before 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **Unvaccinated at 15–59 months:** 1 dose
- For other catch-up guidance, see Table 2.

Special situations

- **Chemotherapy or radiation treatment:**
 - 12–59 months
 - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
 - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
 - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant regardless of Hib vaccination history

- **Anatomic or functional asplenia (including sickle cell disease):**

12–59 months

- Unvaccinated or only 1 dose before 12 months: 2 doses, 8 weeks apart
- 2 or more doses before 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* persons age 5 years or older

- 1 dose

- **Elective splenectomy:**

Unvaccinated* persons age 15 months or older

- 1 dose (preferably at least 14 days before procedure)

- **HIV infection:**

12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* persons age 5–18 years

- 1 dose

- **Immunoglobulin deficiency, early component complement deficiency:**

12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

*Unvaccinated = Less than routine series (through 14 months) OR no doses (14 months or older)

Hepatitis A vaccination

(minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series (**Havrix** 6–12 months apart or **Vaqta** 6–18 months apart, minimum interval 6 months); a series begun before the 2nd birthday should be completed even if the child turns 2 before the second dose is administered.

Catch-up vaccination

- Anyone 2 years of age or older may receive HepA vaccine if desired. Minimum interval between doses: 6 months
- Adolescents 18 years and older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (0, 7, and 21–30 days, followed by a dose at 12 months).

International travel

- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (wwwnc.cdc.gov/travel/):
 - **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2 doses, separated by 6–18 months, between 12 to 23 months of age.
 - **Unvaccinated age 12 months and older:** 1st dose as soon as travel considered

Special situations

At risk for hepatitis A infection: 2-dose series as above

- **Chronic liver disease**
- **Clotting factor disorders**
- **Men who have sex with men**
- **Injection or non-injection drug use**
- **Homelessness**
- **Work with hepatitis A virus** in research laboratory or nonhuman primates with hepatitis A infection
- **Travel** in countries with high or intermediate endemic hepatitis A
- **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before adoptee's arrival)

Hepatitis B vaccination

(minimum age: birth)

Birth dose (monovalent HepB vaccine only)

- **Mother is HBsAg-negative:** 1 dose within 24 hours of birth for **all** medically stable infants $\geq 2,000$ grams. Infants $< 2,000$ grams: administer 1 dose at chronological age 1 month or hospital discharge.

• **Mother is HBsAg-positive:**

- Administer **HepB vaccine** and **0.5 mL of hepatitis B immune globulin (HBIG)** (at separate anatomic sites) within 12 hours of birth, regardless of birth weight. For infants $< 2,000$ grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
- Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.

• **Mother's HBsAg status is unknown:**

- Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
- For infants $< 2,000$ grams, administer **0.5 mL of HBIG** in addition to HepB vaccine within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
- Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **0.5 mL of HBIG** to infants $\geq 2,000$ grams as soon as possible, but no later than 7 days of age.

Routine series

- 3-dose series at 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks
- **Minimum intervals:** dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations)

Catch-up vaccination

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents 18 years and older may receive a 2-dose series of HepB (**Heplisav-B**) at least 4 weeks apart.
- Adolescents 18 years and older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (0, 7, and 21–30 days, followed by a dose at 12 months).
- For other catch-up guidance, see Table 2.

Human papillomavirus vaccination

(minimum age: 9 years)

Routine and catch-up vaccination

- HPV vaccination routinely recommended for all adolescents **age 11–12 years (can start at age 9 years)** and through age 18 years if not previously adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
 - **Age 9 through 14 years at initial vaccination:** 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
 - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- If completed valid vaccination series with any HPV vaccine, no additional doses needed

Special situations

- **Immunocompromising conditions, including HIV infection:** 3-dose series as above
- **History of sexual abuse or assault:** Start at age 9 years
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

Inactivated poliovirus vaccination

(minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after the 4th birthday and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before the 4th birthday when a combination vaccine containing IPV is used. However, a dose is still recommended after the 4th birthday and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- IPV is not routinely recommended for U.S. residents 18 years and older.

Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_cid=mm6601a6_w.

- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements. For guidance to assess doses documented as “OPV,” see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Influenza vaccination

(minimum age: 6 months [IIV], 2 years [LAIV], 18 years [RIV])

Routine vaccination

- 1 dose any influenza vaccine appropriate for age and health status annually (2 doses separated by at least 4 weeks for **children 6 months–8 years** who did not receive at least 2 doses of influenza vaccine before July 1, 2018)

Special situations

- **Egg allergy, hives only:** Any influenza vaccine appropriate for age and health status annually
- **Egg allergy more severe than hives** (e.g., angioedema, respiratory distress): Any influenza vaccine appropriate for age and health status annually in medical setting under supervision of health care provider who can recognize and manage severe allergic conditions
- **LAIV should not be used for** those with a history of severe allergic reaction to any component of the vaccine (excluding egg) or to a previous dose of any influenza vaccine, children and adolescents receiving concomitant aspirin or salicylate-containing medications, children age 2 through 4 years with a history of asthma or wheezing, those who are immunocompromised due to any cause (including immunosuppression caused by medications and HIV infection), anatomic and functional asplenia, cochlear implants, cerebrospinal fluid-orpharyngeal communication, close contacts and caregivers of severely immunosuppressed persons who require a protected environment, pregnancy, and persons who have received influenza antiviral medications within the previous 48 hours.

Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 4 weeks after dose 1.

Catch-up vaccination

- Unvaccinated children and adolescents: 2 doses at least 4 weeks apart
- The maximum age for use of *MMRV* is 12 years.

Special situations

International travel

- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2 doses at 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.
- **Unvaccinated children age 12 months and older:** 2-dose series at least 4 weeks apart before departure

Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months [MenACWY-D, Menactra])

Routine vaccination

- 2-dose series: 11–12 years, 16 years

Catch-up vaccination

- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

Special situations

Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, eculizumab use:

- **Menveo**
 - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
 - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after the 1st birthday)
 - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **Menactra**
 - **Persistent complement component deficiency:**
 - Age 9–23 months: 2 doses at least 12 weeks apart
 - Age 24 months or older: 2 doses at least 8 weeks apart
 - **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
 - **Age 9–23 months:** Not recommended
 - **24 months or older:** 2 doses at least 8 weeks apart
 - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.

Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (wwwnc.cdc.gov/travel/):

- Children age less than 24 months:
 - **Menveo (age 2–23 months):**
 - Dose 1 at 8 weeks: 4-dose series at 2, 4, 6, 12 months
 - Dose 1 at 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after the 1st birthday)
 - **Menactra (age 9–23 months):**
 - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)
- Children age 2 years or older: 1 dose **Menveo** or **Menactra**

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:

- 1 dose **Menveo** or **Menactra**

Note: **Menactra** should be administered either before or at the same time as DTaP. For MenACWY booster dose recommendations for groups listed under “Special situations” above and additional meningococcal vaccination information, see meningococcal *MMWR* publications at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba])

Clinical discretion

- MenB vaccine may be administered based on individual clinical decision to **adolescents not at increased risk** age 16–23 years (preferred age 16–18 years):
- **Bexsero:** 2-dose series at least 1 month apart
- **Trumenba:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2.

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, eculizumab use:

- **Bexsero:** 2-dose series at least 1 month apart
 - **Trumenba:** 3-dose series at 0, 1–2, 6 months
- Bexsero** and **Trumenba** are not interchangeable; the same product should be used for all doses in a series. For additional meningococcal vaccination information, see meningococcal *MMWR* publications at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

Pneumococcal vaccination

(minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13

- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV13

- 1 dose for healthy children age 24–59 months with any incomplete* PCV13 series
- For other catch-up guidance, see Table 2.

Special situations

High-risk conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during same visit.

Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral corticosteroids); diabetes mellitus:

Age 2–5 years

- Any incomplete* series with:
 - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
 - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Cerebrospinal fluid leak, cochlear implant:Age 2–5 years

- Any incomplete* series with:
 - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
 - Less than 3 PCV13 doses: 2 doses PCV13, 8 weeks after the most recent dose and administered 8 weeks apart
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later
- Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent dose of PPSV23

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases

associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years

- Any incomplete* series with:
 - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
 - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2nd dose of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

Chronic liver disease, alcoholism:Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

*An incomplete series is defined as not having received all doses in either the recommended series or an age-appropriate catch-up series. See Tables 8, 9, and 11 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

Rotavirus vaccination

(minimum age: 6 weeks)

Routine vaccination

- **Rotarix:** 2-dose series at 2 and 4 months.
- **RotaTeq:** 3-dose series at 2, 4, and 6 months.

If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Figure 2.

Tetanus, diphtheria, and pertussis (Tdap) vaccination

(minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Adolescents age 11–12 years:** 1 dose Tdap
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td booster every 10 years
- **Persons age 7–18 years not fully immunized with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td.
- **Children age 7–10 years** who receive Tdap inadvertently or as part of the catch-up series should receive the routine Tdap dose at 11–12 years.
- **DTaP inadvertently given after the 7th birthday:**
 - **Child age 7–10 years:** DTaP may count as part of catch-up series. Routine Tdap dose at 11–12 should be administered.
 - **Adolescent age 11–18 years:** Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.
- For information on use of Tdap or Td as tetanus prophylaxis in wound management, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Varicella vaccination

(minimum age: 12 months)

Routine vaccination

- 2-dose series: 12–15 months, 4–6 years
- Dose 2 may be administered as early as 3 months after dose 1 (a dose administered after a 4-week interval may be counted).

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2-dose series:
 - **Ages 7–12 years:** routine interval: 3 months (minimum interval: 4 weeks)
 - **Ages 13 years and older:** routine interval: 4–8 weeks (minimum interval: 4 weeks).
 - The maximum age for use of *MMRV* is 12 years.

Vaccine Management Plan

Wellness Pointe providers and medical staff will adhere to the vaccine management guidelines as detailed in the current Texas Vaccines For Children (TVFC) and Adult Safety Net (ASN) Provider Manual produced by the Texas Department of State Health Services (DSHS).

Vaccine Storage and Handling

I. Method used in developing and approving vaccine storage and Handling

The Wellness Pointe Pediatric department is part of the Federal Vaccines of Children Program (VFC). Texas has been a participant in this program since its inception in 1994. The guidelines for storage and handling of vaccines are detailed in a publication from the Texas Department of Health Services & Texas Health and Human Services.

II. Experience, Training, and/or Education requirements

The Care Coordinator and the clinical coordinator are in charge of handling storing of vaccines and assures that all department personnel comply with the requirements to keep vaccines safe and administered correctly.

III. Circumstances for performance of vaccine storage and handling

The Wellness Pointe Pediatric department has posted and adheres to the Centers for Disease Control's recommendations for handling and storage of selected Biologicals and the Texas Vaccines for Children program guidelines.

IV. Specific requirements to be followed in vaccine administration

A. Proper Equipment for Storage of Vaccines/Biologicals

1. Refrigerators and freezers must contain thermometers capable of recording maximum-minimum temperature readings and data loggers are required beginning January 2018. (See guide for Texas Vaccines for children for specific regulations regarding types of refrigerators and freezers acceptable for use with state vaccines.)

2. The refrigerator compartment must maintain temperatures between 36° F and 46° F (2° C and 8° C) for vaccine viability. Refrigerator temperature should be set at midrange, about 40° F.
3. The freezer compartment should maintain temperatures at or below 5°F and -58F (-15C to -50C)
4. MMR vaccine may be stored either frozen or refrigerated. MMR is sensitive to light and vaccine efficacy could be compromised if left out in the light.
5. All vaccines except Varicella and Zoster are to be stored in the refrigerator and should never be frozen.
6. Diluent may be stored in the door of the refrigerator and can provide extra insulation if needed. Diluent may be stored on a shelf outside of the refrigerator if indicated as such on the diluent. If diluent comes in the same box as the vaccine, it must be kept together with the vaccine in order to maintain the cold chain of the vaccine.
7. It is important that vaccines are kept at the proper temperatures at all times. Opening the door frequently interrupts the cold chain and can result in cumulative loss of vaccine potency over time.

B. Guidelines required for providers involved in handling and storage of vaccines.

1. Check and record internal refrigerator and freezer temperatures on the Temperature Recording Form twice daily. Verify that temperatures are within acceptable range and adjusting the thermostat as necessary only with approval of Care Coordinator/Clinical Coordinator.
2. Store extra water bottles along the walls, back and door of the freezer compartment. This helps keep a steady temperature during the automatic defrosting cycles and provides additional reserves of cold in the event of a power failure. Air must circulate around vaccines freely.

3. All vaccines must be stored on the refrigerator/freezer shelves, not in the vegetable bins, meat drawer, or in the door. Storing vaccines in the central body of the refrigerator/freezer helps maintain vaccine at proper temperatures which are more stable in the body of the refrigerator.
4. Stack vaccines with enough room for cold air to circulate freely around vaccines.

C. Vaccine Management Plan

1. All Pediatric support staff involved in administering vaccines must complete the vaccine provider training as required by the TVFC program.
2. A primary Vaccine Coordinator/Care Coordinator manages the overall operations of the vaccine program with direction from the Clinical Coordinator. The Primary Vaccine Coordinator also orders other vaccines to be administered to patients who do not qualify for the Texas Vaccines For Children program.
3. The Wellness Pointe Pediatric department will order vaccines monthly due to the volume of immunizations given each month.
4. The primary Vaccine Coordinator and the designated backup vaccine coordinator verifies shipment receipts and rotate stock to use vaccines according to expiration dates to reduce vaccine loss for out of date vaccines.
5. The Vaccine Coordinator/Care Coordinator completes monthly reports of vaccine usage, monitoring for loss of vaccines, and current expiration dates. Vaccine Coordinator/Care Coordinator requests additional

supplies of vaccine when expected changes in volume are anticipated.



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6. Any changes to vaccine formulary are to be brought to the Clinical Coordinator and the CMO for approval.
7. All vaccine reports, losses, orders and sign out sheets are to be sent via email to the Clinical Coordinator for review once monthly report is completed.
8. Expired vaccines and loss reports are to be sent to Gregg County and the Clinical Coordinator within 3 days of the loss or expiration of medications.

V. *Method for initial and continuing competency evaluation*

The Clinical Coordinator, a Registered Nurse in the state of Texas and has many years of experience working with vaccines. The Clinical Coordinator continues to assure that all department personnel comply with the requirements to keep vaccines safe and administered correctly. The Clinical Coordinator oversees the Vaccine Coordinator/Care Coordinator and monitors the vaccines monthly. The Clinical Coordinator is also consulted at times when the daily count of vaccines cannot be justified with the log. The entire staff becomes involved when a unique dosing pattern exists for a particular patient.

VI. *Scope of supervision required for performance of vaccine Storage and Handling*

Initial competency for handling vaccines for patients shall be evaluated by the Delegating Provider and the Clinical Coordinator. All non-licensed support staff is initially supervised exclusively for this task. All Pediatric support staff is responsible to maintain the vaccines in proper

temperatures. Only the Gregg County health department staff may transfer state vaccines from one facility to another.



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VII. *Specialized circumstances requiring immediate communication concerning vaccine storage and handling.*

Procedures for vaccine relocation in the event of a prolonged power failure, mechanical difficulty or prolonged delay in planned shipments of vaccine are events that need to be communicated to all Pediatric providers and support staff.

VIII. *Limitations of practice setting for vaccine storage and handling*

The Wellness Pointe Pediatric department handles and stores only vaccines typically used in routine preventive care. The office/department does not deal with specialty vaccines necessary for travel outside of the United States.

IX. *Patient record-keeping requirements*

Vaccine administration, including name and title of administering support staff, and any variations from expected outcomes shall be documented in the center's Electronic Medical Records system according to Center policy. This documentation confirms that the vaccines were stored and handled properly prior to administration.

Issuance of Medications Which Do Not Require a Prescription

I. Method used in developing and approving this order and any revisions

The development and implementation of this order is the product of collaboration between the authorizing physician, midlevel providers, other licensed and/or certified medical staff, and the Compliance & Performance Improvement program. Revisions are considered annually or more frequently as indicated.

II. Experience, training, and/or education requirements

Staff performing functions delegated under this order shall possess the requisite experience, training, and/or education necessary to perform them in the judgment of the delegating provider, as evidenced by the signatures of both on this order.

III. Circumstances for performance of this order

Patients may be issued sample medications to try for a trial period or if they are financially unable to obtain medications at pharmacy.

IV. Specific requirements to be followed in performing particular functions

Clinic staff must document in the Electronic Medical Records system any medications issued to the patient including medication strength, lot number, expiration date, dosing directions, quantity issued and prescribing provider. Staff must also document on the sample medication log using two patient identifiers such as DOB and patient ID.

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v. *Method for initial and continuing competency evaluation*

- a. Initial competency shall be evaluated by the delegating provider and/or Clinical Coordinator by continual observation and supervision of the staff member during the first 90 days of employment.
- b. Continuing competency shall be evaluated no less than annually by the delegating provider and/or Clinical Coordinator by means of annual clinical performance review.

V. *Scope of supervision required for performance of this order*

This order is to be performed only when a licensed, privileged physician or midlevel provider is present on-site

VI. *Specialized Circumstances requiring immediate communication with physician*

VII. *Limitations of practice setting*

This order shall be in force only in the practice setting where the delegating provider is routinely on-site.

VIII. *Patient record-keeping requirements*

The support staff must document in the Electronic Medical Records system as well as on the sample medication log sheet, any medications issued to the patient including medication strength, directions, quantity issued and prescribing provider.

Administration of Drugs Ordered by the Physician

I. Method used in Administration of Drugs Ordered by the pediatric Provider

The Wellness Pointe pediatric department provides care for Well Children needing routine Health Maintenance tasks and for ill children in a variety of stages of illness. At times it is necessary to administer drugs immediately to assist the child in recovery from precipitating condition. These drugs are limited to what is on hand. (See attached list)

II. Experience, training, and/or education requirements

All Pediatric support staff has requisite experience, training, and/or education necessary to administer the medication. The provider, either mid-level or physician assist the support staff as needed to understand the order and administer the medication.

III. Circumstances for Administration of Drugs

Infants and children become ill very quickly and occasionally need medications that will act more quickly than when administered by the oral route. There are also some illnesses that fail to respond to medications given orally and the injectable method is necessary. Occasionally parents will request medications, particularly antibiotics be administered by injection for the ease of administration of the drug to the child.

IV. Specific requirements to be followed when administering drugs

a. Inhalation Medications

Pediatric support staff is trained in the use of the nebulizer and proper dosing is ordered by physician or mid-level provider.

Pediatrics
Administration of Drugs

1. Xopenex or Albuterol can be administered via a hand-held nebulizer to provide relief to an infant or child in respiratory distress. The provider will frequently request that a “breathing treatment” be administered prior to a decision about possible hospital admission or initiation of home therapy.
2. Oxygen is available for emergency situations to assist for respiratory distress until emergency personnel arrive for transport to hospital. Masks in a variety of sizes are available to administer the oxygen if necessary.
- b. Medications administered by injection can be administered by pediatric support staff after receiving the order from physician or mid-level provider.
 1. Pediatric department stocks some basic antibiotics that can be administered Intramuscular, Rocephin, and Bicillin.
 2. The steroid medications Kenalog and Decadron are available for use for children in need of prompt response for respiratory conditions or allergic reactions.
 3. Rarely the pediatric department will give a child a dose of an anti-emetic medication (Phenergan) while in the office.

V. *Method for initial and continuing competency evaluation*

- a. Initial competency for administering medications to children shall be evaluated by the delegating provider and clinical coordinator, who is a Registered Nurse. Each non licensed support staff is initially supervised exclusively for this task during the first 90 days of employment.
- b. Continuing competency shall be evaluated no less than annually by the delegating provider and/or clinical coordinator by means of annual clinical performance review.

VI. *Scope of supervision required be followed when administering drugs*

All support staff administering drugs shall possess the requisite experience, training, and/or education necessary to perform them in the judgment of the delegating provider and clinical coordinator.

VII. *Specialized Circumstances requiring immediate communication with provider.*

In the event that a child suffers an adverse reaction to the administered drug, the staff member will immediately notify the provider in charge and the Chief Medical Officer

VIII. *Limitations of practice setting*

Medications to treat ill children are limited to infants and adolescents enrolled in the services of Wellness Pointe Pediatric Department.

IX. *Patient record-keeping requirements*

Administration of medication, including name and title of administering support staff, and any variations from expected outcomes shall be documented in the Center's Electronic Medical Records system according to Center policy.



Longview Wellness Center, Inc.

Pediatrics
Administration of Drugs

Drugs Available for Administration in the Pediatric Department

Albuterol
Bicillin LA
Dexamethasone
Oxygen
Ondansetron
Tylenol
Ibuprofen
Ceftriaxone
Benadryl

Procedure for Newborn Screening

The State of Texas requires that every baby be screened at 1-2 days and again at 1-2 weeks of age. The screen is done on blood taken from a heel stick and tests for a number of rare disorders that can cause mental retardation or death.

1. Determine that the infant is at least 1 week old and has not had 2nd Newborn Screen collected elsewhere.
2. Gather supplies and complete multilayered form with as much information from chart as possible. Complete this form with information from Mom that might not be readily available in the infant's chart.
3. Obtain a heel warmer device and place around infant's heel to ensure good blood flow and ease the collection.
4. Obtain and wear gloves while collecting blood. Use an automated heel incision device to pierce the infant's heel and apply pressure to infant's foot as needed to encourage blood flow sufficient to fill at least 3 circles on the filter paper portion of the form.
5. Place bank-aid over heel with collection is completed.
6. Place the form in a secure, protected area to allow the blood circles to air dry.
7. Mail the completed, dried form to the Department of State health Services, Laboratory Services Section MC 1947 Austin, TX.
(Preaddressed envelopes are provided by the state lab for this purpose)

Obtaining Physical Findings of Infants and Children

I. Method used to develop procedures for Obtaining Physical Findings

The Wellness Pointe pediatric department provides Well Child Care for children based on the Texas Health Steps Medical Periodicity Schedule for Infants, Children (Birth through 10 years of age) and Adolescents (11 through 20 years of age). The Periodicity Schedule is subject to revision by the Texas State Health Department. Revisions for this pediatric document are considered not less than annually.

II. Experience, training, and/or education requirements

Staff collecting physical findings shall possess the requisite experience, training and/or education necessary to perform them in the judgment of the delegating provider and clinical coordinator. The pediatric staff supervisor or provider is always available to check unusual or unexpected physical findings as necessary.

III. Circumstances for Obtaining Physical Findings

Physical findings are important facts used in the care of patients/clients in all levels of health care. Physical findings are collected and recorded for each visit to the pediatric department. The combination of measurements obtained varies depending on the age of the infant/child and the type of visit scheduled.

IV. Specific requirements necessary to the collection of physical findings

- A. Temperature readings are obtained on all children seen for a provider office visit.
 - 1. Newborn to 2 months of age – Body temperature should be determined using either a rectal or temporal thermometer; preferably rectal.

2. After the age of 2 months, the temperature should be measured using either an axillary or temporal thermometer. The digital ear thermometer can be used on infants older than 6 months of age.
 3. Once old enough to follow instructions, usually at about the age of 4 years and older, body temperature should be determined using the oral method; the axillary, temporal and digital ear thermometers can all be used in this age group.
- B. Obtaining Body Weight measurements of the child.
Body weight for children is an important measure of the child's wellbeing and accurate readings are critical. Body weight measurements should be obtained during all sick and well child visits to the department.
1. Patients up to the age of 12 months should be weighed on the infant scale without clothing (no diaper).
 2. Patients up to the age of 2 years should be placed either laying down or sitting on the tray of the weighing scale.
 3. Children can be weighed standing on the scales when at least 3 years of age and able to stand alone to complete the process.
 4. An estimated weight measurement can be used when the child will not cooperate with this process by weighing both the child and caregiver together, then the caregiver and subtracting to obtain estimated weight for the child. Pediatric support staff uses this method only when other measures to obtain individual weight have failed.
- C. Obtaining Head circumference – Occipital Frontal Circumference.
Head circumference measurements for children are another important measure of the child's wellbeing and accurate readings are critical. Head circumference measurements are obtained at all Well Child Checks until the infant/ toddler is 2 years old.

1. Pediatric support staff each has a special flexible device specific for measuring head circumference of infants and toddlers.
2. The measuring device is placed around the infant's head just above the ears. It is important to measure the widest part of the child's head around the occipital area and to just above the eyebrows on the forehead.
3. Abnormal measurements are verified by the physician or mid-level provider during the physical exam.
4. Infants with abnormal head growth should be evaluated for potential problems.

D. Length/Height Measurements

Length and height measurements for children are another important measure of the child's growth and wellbeing and accurate readings are critical. Length/height measurements are obtained at all Well Child Checks.

1. Pediatric support staff each has a specific device used when obtaining the length of infants. This device is made of flexible plastic so can be readily cleaned between infants.
2. For children under 2 the length is measured while laying flat on this device created specifically for measuring infants. Toddlers.
3. After the child is 2 and able to stand readily the length becomes height and is measured while the child stands against a vertical measuring device secured to the wall.
4. Height measurements are always obtained without shoes for accurate readings of the child's actual height.

E. Waist Circumference Measurement

Waist circumference measurements are an important measurement obtained during the pediatric well child and sick visits. This should begin at the age of 2 years.

1. The support staff should initiate this process by first properly identifying the upper hip bone and the iliac crest of the patient.
 2. The tape measure should then be placed around the abdomen at the level of the iliac crest. The tape should be snug but not compress/squeeze the skin.
 3. The measurement value should be obtained at the end of a normal expiratory cycle.
- F. Obtaining Blood Pressure reading measurements of the child
Blood Pressure measurements for children are an important measure of the child's wellbeing and accurate readings are critical.
1. Routine Blood Pressure readings are obtained routinely for children annually during Well Child Checks starting at age 3, if the child will cooperate.
 2. Blood Pressure measurements are important for some medical conditions no matter the age of the infant/child. These children are identified by a message in the child's chart in the Center's Electronic Medical Records System.
 3. Proper cuff selection is essential when measuring blood pressure in children to obtain accurate and valid readings. The pediatric department has a variety of inflatable rubber cuffs that attach to the Sphygmomanometer. The cuff must cover no more than 2/3 of the infant/child's arm from shoulder to elbow.
- G. Obtaining Pulse and Respiratory measurements:
Respiratory Rate:
1. For patients younger than 2 years of age, count abdominal movements for a total of one minute; record value.
 2. For patients older than 2 years of age, it is advisable to count the respiratory rate in such a manner that the patient is not aware of your intention so as to obtain a more accurate value.

Pulse Rate:

1. The heart rate should be obtained as a means of evaluating the pulse in patients 2 years of age or younger. This is best done by placing the warmed bell or diaphragm of the stethoscope over the infant's chest at the apex of the heart while counting for a total of one minute; record value.
 2. The radial pulse measurement is obtained in patients 2 years and older by applying light pressure with the pads of staff's fingers in the groove along the radial/thumb side of the patient's inner wrist and then counting for thirty seconds; multiply this value by 2 to obtain pulse rate.
- H. Vision and Hearing screens are done on all well child checks after 3 years of age if the child is able to cooperate with the directions, will answer questions and knows his colors, shapes, or letters.
1. Hearing screens should be performed using a screening audiometer in a designated area of the clinic. Each child is tested at 4,000 to 1,000 decibels starting at 25 megahertz. Children who fail the screening without physical findings to indicate reasons for hearing difficulties are referred for specialized audiology testing.
 2. Vision screens are performed using standard Snellen Vision screening charts. The child is positioned at a location 20 feet from the chart and shown the chart with letters, if the child knows his letters. Additional charts in shapes or colors are also available. The child needs to be able to cooperate with the exam for this to be a successful screen. Children who fail the vision screen are referred to Optometry for more testing.
- I. All measurements and results of screens are recorded on the individual child's encounter and in the Center's Electronic Medical Record system. Each child has a growth chart/graph that shows progression over time and relationship to other children of the same age.

V. Method for initial and continuing competency evaluation

- a. Pediatric support staff is given instructions in methods to measure physical findings, vision and hearing screenings by both the clinical coordinator, who is a registered nurse and by individual providers when readings are questionable. Initial competency shall be evaluated by continual observation and supervision during the first 90 days of employment.
- b. Continuing competency shall be evaluated no less than annually by the delegating provider and/or clinical coordinator by means of the annual clinical performance review.

VI. Scope of supervision required for to collect physical findings

All support staff collecting measurements of physical findings or conducting vision and hearing screening shall possess the requisite experience, training and/or education necessary to perform them in the judgment of the delegating provider.

VII. Specialized Circumstances requiring immediate communication with provider

Special circumstances requiring immediate communication with the physician or mid-level provider would include findings outside of expected normal ranges. For example, a body temperature that is well above normal. When measurements do not trend as expected, the pediatric support staff should usually attempt to discover the reason for the discrepancy i.e. repeat measurement and if still abnormal, then notify the provider. For example, a height measurement that is markedly less than a prior exam.

VIII. Limitations of practice setting

Physical findings are important facts used in the care of patients/clients in all levels of health care but are limited to infants, children and adolescents enrolled in the services of Wellness Pointe.

IX. *Patient record-keeping requirements of physical findings*

Physical findings and screening results shall be documented in the Center's Electronic Medical Records system according to Center policy. A growth chart/graph that shows progression over time and relationship to other children of the same age is electronically created using the data recorded.

Ordering of Laboratory/Blood Test for Children

I. Method used for the ordering of laboratory test for children

The Wellness Pointe pediatric department orders routine laboratory test for children based on the Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children (Birth through 10 years of age) and Adolescents (11 through 20 years of age). Revisions are considered not less than annually.

II. Experience, Training, and/or Education requirements

All pediatric support staff delegated to order laboratory test for children have the requisite experience, training, and/or education necessary to conduct this information gathering. The provider, either mid-level or physician assists in making decisions regarding necessary laboratory tests for children in the department.

III. Circumstances for performance of ordering laboratory tests for children

a. Newborn Hereditary/Metabolic Testing

1. All newborn infants have 1st newborn screen drawn while still in the hospital prior to initial discharge after birth.
2. The 2nd Newborn Screen need to be drawn after the infant has been taking milk for at least 72 hours; this test is usually done after the infant is 7 days old. Pediatric support staff performs this task after requisite experience, training, and/or education. (See Procedure for Newborn Screens).

b. Anemia Screening – Blood for pediatric patients is drawn by qualified personnel.

1. Blood is drawn from infants 12 months of age to assess Hemoglobin levels so that dietary supplementation can be started for those infants who are anemic.

2. Routine Hemoglobin screening is conducted for new patients seen in the pediatric department who receive government assistance with Health Care Services.
 - c. Lead Screening – Blood for Pediatric Patients is drawn by qualified personnel.
 1. Blood is drawn from children at 1yr and 2yr routinely to measure levels of lead in the blood stream.
 2. All children regularly seen in the pediatric department must have 2 lead levels prior to age 4 or one lead test before or at 6 years of age.
 - d. Other laboratory test may be ordered by the support staff for children in the pediatric department but these orders are at the direction of the physicians or mid-level providers. Any laboratory test that needs to be reported promptly is physically transported to a local laboratory for immediate processing. Other laboratory testing is transported to another location and results are returned thru the center's Electronic Medical Records (EMR) system.
- IV. Specific requirements to be followed to be followed in ordering laboratory tests for children.
- a. Newborn Screening forms are specific for this task and are designed, distributed and revised by the Texas Department of State Health Services Laboratory Services Section. These forms are collected and mailed to the state lab daily. Results are obtained and recorded in individual child's chart.
 - b. Orders for blood samples to be collected for Hemoglobin and Lead levels are generated in the center's Electronic Medical Records (EMR) system according to center policy.

1. The order is generated by the clinical staff in the EMR system for the individual child. After the physical exam has been completed the order is routed to the laboratory.
2. Laboratory personnel obtain the blood samples based on the testing ordered and place in designated location for processing. Blood is collected in special containers designed for this purpose obtained from the state laboratory in Austin.
3. Designated pediatric support personnel enter the individual information into Texas Department of State Health Services Orchard® Harvest software system to process the order. The samples are then packaged for mailing to the state laboratory in Austin for processing.

V. Method for initial and continuing competency evaluation

- a. Initial competency for ordering laboratory tests shall be evaluated by the delegating provider and clinical coordinator, who is a registered nurse. Each non licensed support staff is initially supervised exclusively for this task during the first 90 days of employment.
- b. Continuing competency shall be evaluated no less than annually by the delegating provider and/or staff supervisor by means of the annual clinical performance review. Competency in obtaining blood specimens is verified when the samples are suitable for processing and results are obtained in a timely manner.

VI. Scope of supervision required for ordering of laboratory tests for children

All support staff collecting blood samples, ordering tests or processing the samples shall possess the requisite experience, training, and/or education necessary to perform them in the judgment of the delegating provider.

VII. Specialized circumstances requiring immediate communication with physician.

a. Adverse Reaction

In the event that a child has an adverse reaction to the blood collection process, the staff member will immediately notify the Provider in Charge, and/or the Chief Medical Officer.

b. Parental Decisions

Parents have the right to decline to have blood collected from their children. Support staff will discuss this with the Provider in Charge of the individual child. The Wellness Pointe pediatric department has documents that parents must sign to confirm this decision.

VIII. Limitations of practice setting

Routine blood screening is conducted for patients seen in the pediatric department who receive government assistance with Health Care Services. Blood screening is available to all children but for those without Health Care assistance, the cost is frequently prohibitive.

IX. Patient record – keeping requirements

All laboratory tests ordered, collected and results obtained shall be documented in the center's Electronic Medical Records system according to center's policy.

Risk Assessment for Lead Exposure

1. Do you live in or visit often a house that was **probably** built before 1978?
2. Does your child live in or often visit a house that is being painted, remodeled, or having the paint scraped or sanded?
3. Does your child eat or chew on non-food things like paint chips or dirt?
4. Have any other members of the family or your child's playmates had high blood lead levels as far as you know?
5. Does your family live near or does your child play near any of these?

Smelter

Hazardous waste site

Lead industry

Place where batteries are manufactured or repaired

House construction site

Heavily traveled major highway

Place where cars are abandoned or repaired

6. Do you give your child, or have you ever given your child, any of these products from another country:

MEDICINES like greta or azarcon for empacho, Alarcon, alkohl, bali goli, coral, ghasard, liga pay-loo-ah, or rueda?

NUTRITIONAL PILLS other than vitamins?

7. Does anyone living in your house work at a place where any of these things happen or have a hobby that involves these things (**circle** the ones that apply)

Radiator repair

Lead industry

Battery manufacture or repair

Welding

Smelting

House construction or repair

Chemical preparation

Making pottery

Going to a firing range

Stained glass with lead solder

Brass/cooper foundry

Valve and pipe fittings

Bridge, tunnel and elevated highway construction

Industrial machinery and equipment

Re-loading bullets or making fishing weights

Refinishing furniture

Burning lead-painted wood

Automotive repair shop

8. Does anybody that your child spends a lot of time with (outside of your home) do any of these things or work at a place where these things are done?

9. Is imported or glazed pottery, or a Mexican bean pot, used to cook or store your food?
10. Does your child eat foods canned or packaged (such as candy) outside the United States?

Interview Questions when blood level lead is high

When the capillary lead level value is above 9 ug/dL, the infant/child is recalled to the office for a specific venous blood lead level. At that time Pediatric support staff review the following questions with the family/caregivers.

1. Was your home probably built before 1978?
2. How long have you lived at this address?
3. What was your previous address?
4. Is there any peeling paint on the outside or inside of your home?
5. Has any recent remodeling of your home involved paint removal or the use of old or recycled lumber?
6. If your house is heated by a wood-burning stove or fireplace, is painted wood burned as fuel?
7. Does your child spend time at any other building (Daycare, grandparents' house, neighbor's house, etc) that was probably built before 1978 or that has had recent renovations?
8. Have other members of the family or any of your child's friends had high blood lead levels?
9. Does your child eat candy imported from other countries, especially from Mexico?
10. Does your child put non-food items, like paint or dirt, in his/her mouth?
11. Are there factories near the place where your child spends most of his time?
12. Does anyone in the home make bullets, fishing weights, stained glass, pottery, or work on automobiles near the house?
13. Where are members of your household employed? What is their main job?
14. Are acid-containing foods like fruit juices stored in pottery, porcelain, pewter, leaded crystal, or cans?
15. Do you cook or store food in a bean pot or in pottery that is glazed?
16. Does anyone in your family use alternative, traditional, or home remedies, such as Greta, Azarcon, Maria Luisa, or Pay-loo-ah?

Reference for Blood Lead Retesting and Medical Case Management

- Immediately retest the child if the blood lead level (BLL) is unsatisfactory (e.g. "Clotted" or "insufficient quantity").
- Follow the flowchart below to determine when retesting and medical case management is necessary.

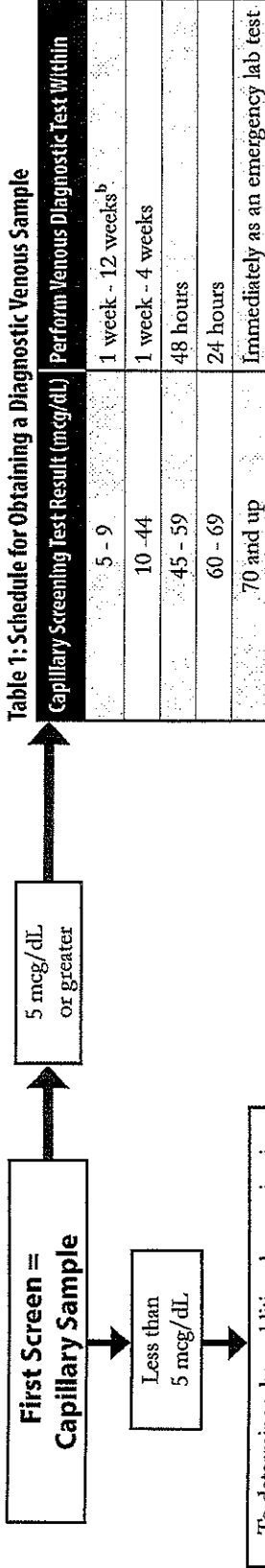


Table 1: Schedule for Obtaining a Diagnostic Venous Sample

Capillary Screening Test Result (mcg/dL)	Perform Venous Diagnostic Test Within
5 - 9	1 week - 12 weeks ^b
10 - 44	1 week - 4 weeks
45 - 59	48 hours
60 - 69	24 hours
70 and up	Immediately as an emergency lab test

Table 2: Schedule for Venous Blood Lead Testing

Venous Blood Lead Level (mcg/dL)	Early Retesting (first 2-4 tests after identification)	Late Retesting (after BLL begins to decline)
5 - 9	3 months - 6 months	6 months - 9 months
10 - 14	3 months	6 months
15 - 19	1 month - 3 months	3 months - 6 months
20 - 24	1 month - 3 months	1 month - 3 months
25 - 44	2 weeks - 1 month	1 month
45 and up	As soon as possible	Chelation with subsequent retesting ^f

Table 3: Medical Case Management for Children with a Diagnostic Elevated Blood Lead Levels

5 - 9 mcg/dL	10 - 14 mcg/dL	15 - 19 mcg/dL	20 - 44 mcg/dL	45 - 69 mcg/dL	70 or higher mcg/dL
<ol style="list-style-type: none"> Lead Education: Dietary & Environmental Continued BLL monitoring Environmental Lead investigation if: <ul style="list-style-type: none"> BLLs persist at least 12 weeks after diagnostic venous test 	<ol style="list-style-type: none"> Lead Education: Dietary & Environmental Continued BLL monitoring Environmental Lead investigation if: <ul style="list-style-type: none"> BLLs persist at least 12 weeks after diagnostic venous test 	<ol style="list-style-type: none"> Lead Education: Dietary & Environmental Continued BLL monitoring Proceed according to actions for 20-44 mcg/dL if: <ul style="list-style-type: none"> BLLs persist at least 12 weeks after diagnostic venous test 	<ol style="list-style-type: none"> Lead Education: Dietary & Environmental Continued BLL monitoring Complete history and physical exam Lab work: Hemoglobin or hematocrit; Iron status Environmental Lead Investigation Lead hazard reduction Neurodevelopmental monitoring Abdominal X-ray (if particulate lead ingestion is suspected) with bowel decontamination if indicated 	<ol style="list-style-type: none"> Lead Education: Dietary & Environmental Continued BLL monitoring Complete history and physical exam Complete neurological exam Lab work: Hemoglobin or hematocrit; Iron status; FEP or ZPP Environmental Lead Investigation Lead hazard reduction Neurodevelopmental monitoring Abdominal X-ray with bowel decontamination if indicated Chelation therapy^e 	<ol style="list-style-type: none"> Hospitalize and commence chelation therapy^e Proceed according to actions for 45-69 mcg/dL

^aBlood Lead Screening and Testing Guidelines for Texas Children: Quick Reference Guide. Go to: www.dshs.state.tx.us/lead. ^bThe higher the blood lead level on the screening test, the more urgent the need for diagnostic testing. ^cHealthcare providers should consult with an expert in the management of these lead levels before administering chelation. Chelation therapy should never be administered before a venous diagnostic is obtained.

Follow these 4 steps to follow-up on a child with an elevated blood lead level (EBLL)

STEP 1. Provider and Patient Information

Provider Information (Please print clearly)				
Provider's Name _____			Clinic Name _____	
Mailing Address _____	City _____	State _____	Zip _____	County _____
() _____	() _____			
Telephone _____	Fax _____	Date _____		
Patient Information (Please print clearly)				
Child's Last Name _____		First Name _____		M.I. _____
Date of Birth (mm/dd/yyyy) _____		Medicaid Number _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ Language Spoken (check one)	
() _____		() _____		
Parent/Guardian's Name _____		Telephone _____	Alternate Telephone _____	
Physical Address/ Apt. # _____		City _____	State _____	Zip _____

STEP 2. Child's Blood Lead Test Results

List sample type (Capillary or Venous)	Results (mcg/dL)	Date (mm/dd/yy)	Laboratory, Address, City, State (where analysis conducted)

STEP 3. Complete Questions Below

1. Is the child continuing in your care? Yes No
2. Have you documented sending reminder letters or calling for follow-up? Yes No
3. Is the child lost to follow-up because they have moved? Yes No
If yes, have you made a referral to Texas Health Steps/Maximus? Yes No
4. Is the child lost to follow-up because the parent/guardian is non-compliant? Yes No
If yes, have you made a referral to Case Management for Children and Pregnant Woman (CPW)? Yes No
5. Has the child been referred to another healthcare provider? Yes No
If yes, New Physician and Clinic: _____
Mailing Address: _____
Phone: _____
6. Does the child meet the requirements below for an Environmental Lead Investigation:
 - The child's **VENOUS** blood lead test result is 20 mcg/dL and higher Yes No
 - Two separate **VENOUS** blood lead level tests collected at lead 12 weeks apart in the 10-19 mcg/dL range. Yes No
If yes, has an ELI been arranged or conducted? Yes No
7. If patient is **younger** than 3 years old, have you made a referral to Early Childhood Intervention Services? Yes No

Step 4. Fax completed form with all laboratory blood lead tests results to:
Texas Childhood Lead Poisoning Prevention Program, Fax: 512-776-7699



Childhood Blood Lead Level Report

Form 09-11709

Confidential Medical Record

Send to: Texas Childhood Lead Poisoning Prevention Program Texas Department of State Health Services PO Box 149347, MC1964 Austin, TX 78714 Fax Number: (512) 776-7699 Phone Number: (512) 776-6632 or 1-800-588-1248 (Toll-free)	From: Provider Name: City/State/ZIP: Phone Number: () Fax Number: ()
---	---

Child Information		
Last Name:	First Name:	M.I.
Date Birth: ____ / ____ / ____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Age in Months:	Medicaid# /CHIP ID#:	
Current Address:	Apartment #:	
City:	State:	Zip:
Ethnicity: (check one)		
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Unknown
Child Race: (check one)		
<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> Native American or Alaskan Native	<input type="checkbox"/> Multi-Racial	<input type="checkbox"/> Unknown

Blood Lead Level Information	
Blood Lead Test Level: _____ micrograms per deciliter(mcg/dL)	Blood Draw Date: ____ / ____ / ____
Type of Blood Sample: (check one)	
<input type="checkbox"/> Capillary	<input type="checkbox"/> Venous <input type="checkbox"/> Unknown
Testing Laboratory:	If Using LeadCare System, Place Label Here
Laboratory Phone: ()	

Attending Physician Information	
Last Name:	First Name:
Location (City):	

For TX CLPPP Use Only	
Person Receiving Report:	Date Received: ____ / ____ / ____



Provider: Administer this form to the parent or guardian to find possible source(s) of lead exposure.

Provider and Patient Information

Provider Information <i>(Please print clearly)</i>				
Provider's Name (Last, First)			Clinic Name	
Mailing Address		City	State	Zip
County				
Telephone () / ()		Fax () / ()		
Job Title		Signature		Date
Patient Information <i>(Please print clearly)</i>				
Child's Last Name		First Name		M.I.
Date of Birth (mm/dd/yyyy)		Medicaid Number	Language Spoken (check one)	
Parent/Guardian's Name		Telephone () / ()	Alternate Telephone	
Physical Address/ Apt. #		City	State	Zip
Mailing Address/ P.O. Box (if different from physical)		City	State	Zip

<input type="checkbox"/> Yes <input type="checkbox"/> No Primary Address (check one)

Interview Questions

1. Was your home probably built before 1978? Yes No
 ¿Se construyó su casa probablemente antes de 1978?
2. How long have you lived at this address?
 ¿Cuánto tiempo ha vivido en esta dirección? (Years/Años) _____ (Months/Meses) _____
3. What was your previous address? _____
 ¿Cuál era su dirección anterior? _____
4. Is there any peeling paint on the outside or inside of your home? Yes No
 ¿Hay pintura desprendida en tiras dentro o fuera de su hogar?
5. Has any recent remodeling of your home involved paint removal or the use of old or recycled lumber? Yes No
 ¿Ha habido renovaciones recientes de su hogar que hayan involucrado el removimiento de pintura o el uso de maderas viejas o recicladas?
6. If your house is heated by a wood-burning stove or fireplace, is painted wood burned as fuel? Yes No
 Si calienta usted su casa con estufa de leña o chimenea ¿Quema usted madera recubierta de pintura como combustible?



Possible Sources of Lead Exposure: Interview Questions

Form Pb - 100

7. Does your child spend time at any other building (daycare center, grandparent's house, neighbor's house, etc.) that was probably built before 1978 or that has had recent renovations? [] Yes [] No

¿Pasa su niño o niña tiempo en algún otro edificio (centro de guardería, de los abuelos, casa de vecinos, etc.) que probablemente halla sido construido antes de 1978 o que haya tenido renovaciones recientes?

What is the address? _____

¿Cuál es la dirección? _____

8. Have other members of the family or any of your child's friends had high blood lead levels? [] Yes [] No

¿Han tenido otros miembros de la familia o cualquiera de los amigos de sus niños altos niveles de plomo en la sangre?

If yes, who? _____

¿Si su respuesta fue si, quienes? _____

9. Does your child eat candy imported from other countries, especially from Mexico? [] Yes [] No

¿Su hijo(a) come dulces importados, especialmente de México?

10. Does your child put non-food items, like paint or dirt, in his/her mouth? [] Yes [] No

¿Se lleva a lo boca, su niño o niña, cosas no comestibles (como pintura o tierra)?

11. Are there factories near the place where your child spends most of his time? [] Yes [] No

¿Se encuentran fábricas cerca del lugar en donde su niño o niña pasa la mayor parte del tiempo?

12. Does anyone in your home make bullets, fishing weights, stained glass, pottery, or work on automobiles near the house? [] Yes [] No

¿Alguien en su hogar manufactura balas, pesas para cañas de pescar, vidrio de colores; que manufacture o apliqué vidriado a la cerámica o que arregle autos cerca de la casa?

13. Where are members of your household employed? _____

¿En dónde trabajan los miembros de su familia? _____

What is their main job? _____

¿Principalmente en qué trabajan? _____

14. Are acid-containing foods like fruit juices stored in pottery, porcelain, pewter, leaded crystal, or cans? [] Yes [] No

¿Almacena usted comida de alto contenido de ácido, como jugos de fruta, en recipientes de barro, porcelana, peltre, cristal de plomo, o en latas?

15. Do you cook or store food in a bean pot or in pottery that is glazed? [] Yes [] No

¿Cocina o guarda usted comida en olla para frijoles, en alfarería recubierta con vidriado que contenga plomo?

16. Does anyone in your family use alternative, traditional, or home remedies, such as Greta, Azarcon, Maria Luisa, or Pay-loo-ah? [] Yes [] No

¿Hay alguno de su familia que use remedios alternativos, tradicionales, o caseros, como Greta, Azarcon, María Luisa, o Pay-loo Ah?

17. Was lead education provided to the parent/guardian in the form of:

Printed Material (brochure, pamphlet), and/or [] Yes [] No

Provider-Parent counseling? [] Yes [] No

FREE lead education materials are available online at http://www.dshs.state.tx.us/lead/parents.shtm.

TX CLPPP Lead Education Topics and Printed Materials

- Environmental Interventions (supply parent with educational material #1-307, #1-308, #1-315, #09-13409)
Nutritional Interventions (supply parent with educational material #EPA-747-F-01-004)
Medical Care (supply parent with educational materials #1-311)

Child's First Name: _____
Child's Last Name: _____

Parent: _____
Date: ____ / ____ / ____

Environmental Interventions (supply parent with educational materials #1-307, #1-308, #1-315, #09-13409)

- Potential sources of lead
 - Lead paint
 - Lead contaminated dust and soil
 - Lead contaminated water from lead pipes or lead solder
 - Imported mini-blinds
 - Home remedies (Azarcon or Greta)
 - Lead contaminated food from storage in ceramic pottery, leaded crystal, and lead soldered cans
 - Occupations and hobbies
- Certified professionals should conduct lead abatement
- Methods to reduce their child's lead exposure
 - Create barriers between living/play areas and lead sources (i.e. tape over lead painted windowsills or doorframes, plant grass in bare soil areas)
 - Wash child's hands and face before meals and at bedtime
 - Wash child's toys, pacifiers, and bottles often
 - Wet mop floors regularly and wet wipe window components
 - Vacuum carpeted areas before wet mopping floors
 - Keep child from eating nonfood items
 - Keep child away from peeling, chipping, or flaking paint
 - Prevent child from playing in bare soil areas
 - Keep child away from areas where lead is being used (i.e. hobbies, occupations)
 - Relocate if lead contamination is extensive and not easily remediable
- Potential water hazards
 - Do not cook with or allow children to drink hot tap water
 - Run cold tap water for 1-2 minutes in the morning and fill a pitcher with the water. Use this water for drinking, cooking, and formula preparation
 - Use bottled water if drinking water is contaminated

Nutritional Interventions (supply parent with educational material #EPA-747-F-01-004)

- Feed child foods rich in absorbable iron, vitamin C, and calcium
- Feed child three healthy meals and two nutritious snacks each day
- Use glass, plastic, or stainless steel containers for storing, preparing, or serving food

Medical Care (supply parent with educational material #1-311)

- The importance of recommended medical follow-up
 - After the blood lead level goes below 4.5 µg/dL, screen children for lead at least once a year up to the age of 6
- Risks associated with elevated blood lead levels

Download educational materials by visiting www.dshs.state.tx.us/lead
and clicking on the "Educational Materials" link.

If you have any questions or comments about lead, please contact the Texas
Childhood Lead Poisoning Prevention Program by phone at 1-800-588-1248.

Taking of Personal & Medical History

I. Method used in developing and approving taking personal/ medical history

The development and implementation of procedures to obtain personal/medical history information have been designed by the supervising physicians in Pediatrics. Revisions are considered not less than annually.

II. Experience, training, and/or education requirements

Support staff obtain personal and medical history during each routine visit either well child checks or when the child is ill. The details for the history depend on the age of the child and purpose of the visit to the clinic. All pediatric support staff has requisite experience, training, and/or education necessary to conduct this information gathering. The provider, either mid-level or physician makes modifications to the history during each visit.

III. Circumstances for taking personal/medical history

Personal and Medical History information are obtained from patients or parents during each visit. The medical history is obtained at initial visit by the support pediatric staff and updated by the support staff as events occur during the life of the child. The details for the history depend on the age of the child and purpose of the visit to the clinic.

IV. Specific requirements to be followed when taking personal/medical history

Gathering information about medical history can be difficult in the pediatric setting due to frequent changes in the living arrangements for the children; parents and caregivers failure of memory for details; reluctance to share necessary information for fear of legal consequences or simply failure to recognize the importance of medical information.

V. Method for initial and continuing competency evaluation

- a. Initial competency for support staff shall be evaluated by the delegating provider and clinical coordinator, who is a Registered Nurse. Each non licensed support staff is initially supervised exclusively for this task during the first 90 days of employment.
- b. Continuing competency for support staff shall be evaluated no less than annually by the delegating provider and/or clinical coordinator by means of annual clinical performance review.

VI. Scope of supervision required for Taking personal/medical history

All staff members in pediatrics participate in vigorous training with a variety of children of various ages during the orientation to the unit. All histories are reviewed by the practitioner doing the exam for the child, either mid-level or physician. All staff may make modifications and additions to the history as changes occur.

VII. *Specialized Circumstances requiring immediate communication with physician*

Immediate communication with supervising physician or mid-level provider would involve information obtained in the medical history of past or present illness that is immediately life-threatening or situations related to custody of the child in question.

VIII. *Limitations of practice setting*

Only personnel involved in providing health care for these children will have access to this information. Limitations for obtaining personal/medical history include: changes in living arrangements for the children or changes in custody, families moving from place to place for employment situations and frequently changing primary medical providers.

IX. *Patient record-keeping requirements*

Personal and Medical History information for all pediatric patients shall be documented in the Center's Electronic Medical Records system according to Center policy.

Provision of General Patient Education

I. Method used in developing plans for General Patient Education for children

The Wellness Pointe pediatric department provides some general education for children/families based on the Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children and Adolescents (Birth through 10 years of age) and (11 through 20 years of age). The Periodicity Schedule is subject to revision by the Texas State Health Department. Revisions for the pediatric department are considered not less than annually.

II. Experience, training, and/or education requirements

All Pediatric support staff has the requisite experience, training and/or education necessary to discuss General Child/Patient Education information. The provider, either mid-level or physician assists the support staff as needed to help families/caregivers understand information discussed.

III. Circumstances for performance of General Patient Education

The Periodicity Schedule follows the standards established by the American Academy of Pediatrics recommendations for Preventative Pediatric Health Care. These standards are a nationwide standard of care for pediatric practices based on care for children receiving competent parenting. General patient/parent education and anticipatory guidance are also components of the Early and Periodic Screening Diagnosis, and Treatment (EPSDT) mandated by Medicaid's comprehensive and preventative child health program for individuals under the age 21.

IV. *Specific requirements necessary for General Patient Education*

The center's Electronic Medical Records system has been established to present a variety of items for patient education at each scheduled Well Child Check.

- A. Dietary Concerns – Type and amount of formula/breast milk, initiation of solids, which solids are able to tolerate, when switch from formula to regular milk, whether child enrolled in WIC program and if drinks water that has been fluorinated.
- B. Development questions – Several general questions to help the provider identify potential problems with development. A more detailed Developmental assessment is conducted by the provider.
- C. Child's general health since previous visit – Any major illnesses, trips to ER, surgeries, overnight stay in hospital as well as any current health concerns to be addressed.
- D. Health Education/Injury Prevention – Based on the age of the child and changing as the child grows, deals with thing like sleeping position for infants to driving for adolescents. Each age is slightly different in hopes that family's will be consistent in coming for Well Child Check and have benefits from different educational focus at each visit.
- E. Educational questions about behavior – Also based on the age of the child include information about how a child sleeps to his behavior toward parents to attitudes about school.

V. *Method for initial and continuing competency evaluation*

- a. Initial competency shall be evaluated by the delegating provider and clinical coordinator, who is a registered nurse. Each non licensed support staff is initially supervised exclusively for this task during the first 90 days of employment.

- b. Continuing competency shall be evaluated no less than annually by the delegating provider and/or clinical coordinator by means of the annual clinical performance review. Education topics are also covered by the provider during the physical exam.

VI. *Scope of supervision required for performing General patient Education*

All support staff performing/assisting with Well Child Checks shall possess the requisite experience, training and/or education necessary to perform them in the judgment of the delegating provider.

VII. *Specialized Circumstances requiring immediate communication with provider*

When the General Education topic provided or offered to parents generates questions that the support staff is not able to answer, there should be immediate communication and consultation with the provider/physician.

VIII. *Limitations of practice setting*

Pertinent education topics apply to children with general medical or mental health problems but are not to be considered sufficient for management of complex health problems. These standards apply to well children developing at expected stages.

IX. *Patient record-keeping requirements*

General Patient/parent education topics shall be documented in the Center's Electronic Medical Record system according to Center Policy.

Patient Telephone Calls

I. Method used in developing and approving this order & any revisions

The development and implementation of this order is the product of collaboration between the authorizing physician, midlevel providers, and other licensed and/or certified medical staff, and the Compliance & Performance Improvement program. This order is reviewed and revisions are considered annually or more frequently as indicated.

II. Experience, training, and/or education requirements

Staff performing functions delegated under this order shall possess the requisite experience, training and/or education necessary to perform them in the judgment of the delegating provider, as evidenced by the signatures of both on this order.

III. Circumstances for performance of this order

We will attempt to answer all phone calls as they are received. However, in the event a call cannot be answered immediately, the following procedure will be followed:

IV. Specific requirements to be followed in performing particular functions.

A. The designated phone line (ext. 246) will be checked a minimum of three times each day: 8am, 1pm, and 4pm. Each call will be documented in a phone log with the following information:

1. Date and time of call
2. Person calling
3. Patient ID#
4. Call back number
5. Question(s)/Concern(s)

- B. The following calls can be returned by support staff
 - 1. Verification of appointment date/time
 - 2. Rescheduling of a missed appointment
 - 3. Medication refill requests
 - 4. Confirmation of lab/imaging results
 - 5. Confirmation of referral(s)
- C. The following calls must be discussed with a provider:
 - 1. Question regarding medication/possible side effect
 - 2. Question regarding medical decision making
 - 3. Emergency situations where patient was told to call 911/sent to ER

V. *Method for initial and continuing competency evaluation*

- a. Initial competency shall be evaluated by the delegating provider and clinical coordinator, who is a registered nurse by continual observation and supervision of the staff member during the first 90 days of employment.
- b. Continuing competency shall be evaluated no less than annually by the delegating provider and/or clinical coordinator by means of annual clinical performance review.

VI. *Scope of supervision required for performance of this order*

All support staff shall possess the necessary experience, training and/or education to carry out these tasks as delegated by the provider.

VII. *Specialized Circumstances requiring immediate communication with Physician*

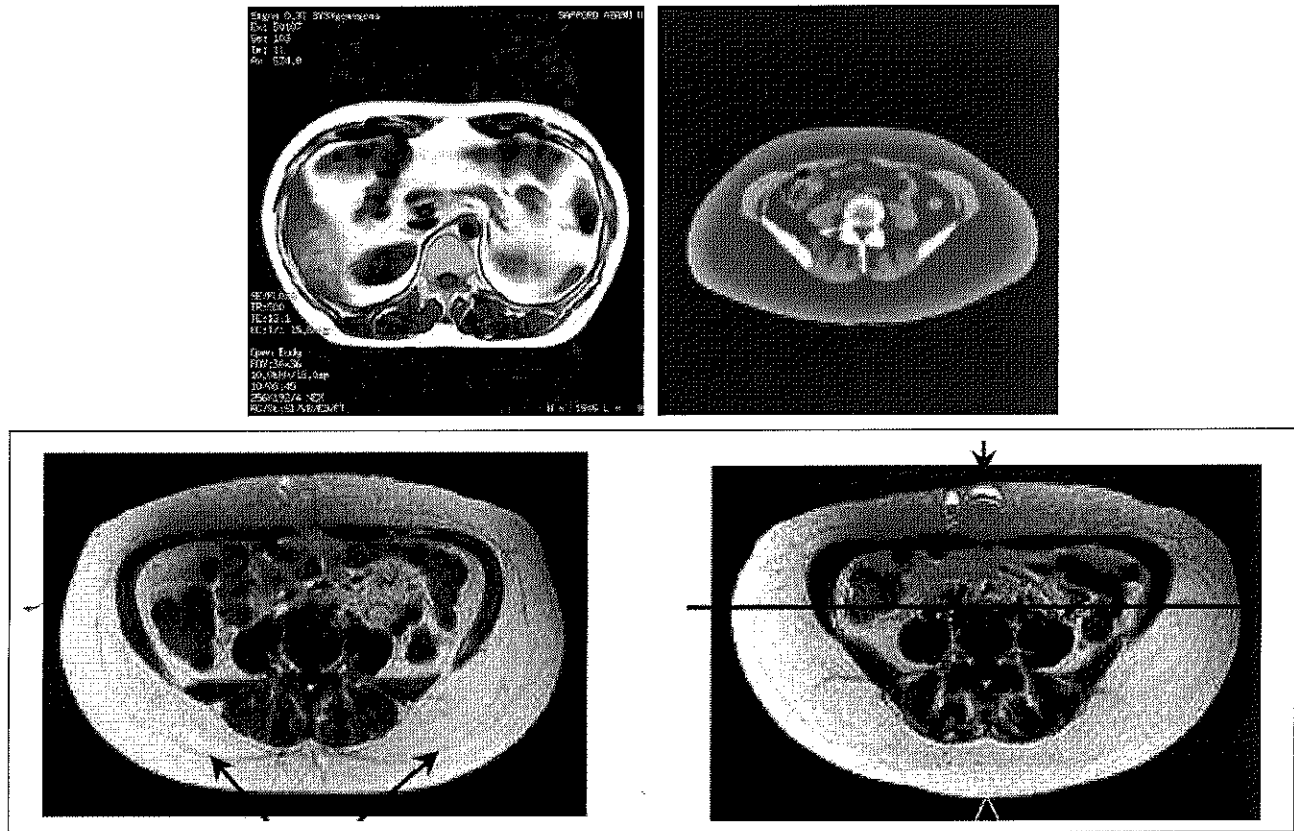
All calls concerning suicidal/homicidal/psychotic behavior or possible reaction to medication will immediately staffed and patient will be instructed to call 911 or go to the nearest ER. Every effort will be made to address the patient's concern immediately.

VIII. Limitations of practice setting

This order shall be in force only in the practice setting where the delegating provider is routinely on-site and/or readily available.

IX. Patient record-keeping requirements

Performance of this order and resultant findings shall be documented in the Center's Electronic Medical Records system according to Center policy.

Figure 2. Visceral and subcutaneous fat on cross-section

Measure Waist Circumference

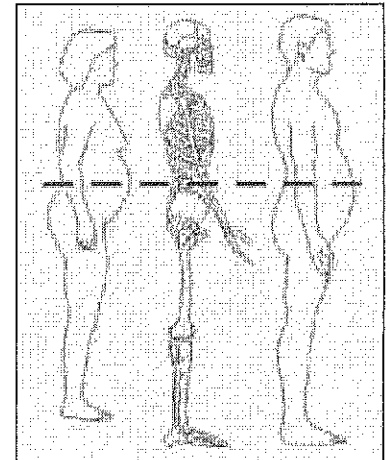
Visceral adipose tissue (Figure 2) is fat tissue found in the intra-abdominal cavity and is an important component of excess central fat tissue because it has been shown to have different metabolic properties than subcutaneous fat. Excess visceral fat is associated with increased insulin resistance and dyslipidemia related to free fatty acid turnover.

Consider measuring waist circumference in children and adolescents who are overweight but not obese (BMI below the 95th percentile) but whom you think may have excess central fat.^{10,18,19} To measure waist circumference (Figure 3)

- Locate the upper hip bone and the iliac crest.
- Place a measuring tape in the horizontal plane around the abdomen at the level of the iliac crest. Ensure that the tape is snug but does not compress the skin and is parallel to the floor.
- Take the measurement at the end of a normal expiration.

Figure 3. Measuring waist circumference.^a

To measure waist circumference, locate the upper hip bone and the top of the right iliac crest. Place a measuring tape in a horizontal plane around the abdomen at the level of the iliac crest. Before reading the tape measure, ensure that the tape is snug, but does not compress the skin, and is parallel to the floor. The measurement is made at the end of a normal expiration.



Measuring-Tape Position for Waist (Abdominal) Circumference in Adults

^aSource: National Institutes of Health. Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults—the evidence report. National Institutes of Health. *Obes Res.* 1998;6(suppl 2):51S–209S.

For children younger than 18, values above the 90th percentile reflect an excess of central adipose tissue for age and sex (Table 2).

For adolescents older than 18, males with waist circumference greater than 40 inches (>102 cm) or females with waist circumferences greater than 35 inches (>88 cm) exceed the criteria for the adult definition of metabolic syndrome (Table 2). The high normal values from smoothed growth curves are meant to transition measures of excess abdominal fat during adolescence to abdominal obesity in adulthood at age 18.¹⁶

Table 2. Waist Circumference (cm) Cutoffs for Males and Females for > 50th and > 90th and for Age/Gender Specific High-Normal Values That Correlate to Adult Cut Offs

	Males			Females		
	50th	90th	High-Normal 91st	50th	90th	High-Normal 75th
Age						
2	48	53	53	48	53	50
3	50	55	55	50	56	53
4	52	58	58	52	59	55
5	53	61	61	53	61	57
6	55	64	65	55	64	59
7	57	69	69	57	69	62
8	60	73	74	60	73	66
9	63	78	79	63	78	69
10	65	83	83	66	83	73
11	68	87	87	70	87	78
12	71	91	91	73	91	81
13	73	94	95	75	94	83
14	75	96	97	76	96	85
15	77	98	99	77	97	86
16	79	100	100	78	98	87
17	80	101	101	79	99	87
18	81	101	102	79	100	88
Adult			102 cm			88 cm

The cut-off for abdominal obesity for men is 102 cm and for women it is 88 cm according to the NCEP guidelines. The 91st percentile curve for boys and the 75th percentile curves line for girls represent a smooth growth curve line that transitions into the respective adult cut-off values for abdominal obesity.

Source: Adapted from Table IB from Cook et al.¹⁶

What Should You Do With an Abnormal Result?

Follow Up

Abnormal laboratory values from a single point are not diagnostic for any obesity comorbidity like hypertension or hypercholesterolemia. Follow up with the patient and family relatively soon after these results come in.

Inform the patient and family of the abnormal results.

- Assess and assist patients with weight maintenance or weight loss efforts.
- Guide further or additional screening for cardio-metabolic complications of obesity such as NAFLD or PLOS.

Provide Treatment and Counseling

Overweight and Obesity

Weight loss is the primary target for treating cardio-metabolic abnormalities of obesity. Include family members when behavioral change for weight loss is the goal.^{4,18} This is especially true for this cardiometabolic clustering for 2 reasons.

- The clustering of abnormalities in metabolic syndrome occurs in adults and their offspring. Parents with the syndrome are very likely to have children with the syndrome.^{20,21} If one or both parents are overweight, they will benefit from behavior changes that lead to weight loss in the child.
- Parent behavior change and weight loss are some of the strongest predictors of child weight loss.²²

A general low-calorie diet with reduced total fat, as recommended by National Institutes of Health guidelines and the American Heart Association, will benefit the whole family.^{4,23} The child and parents should partner with behavior changes around food and avoid so-called fad diets.






Regular daily exercise, preferably 60 minutes of moderate to vigorous physical activity, is recommended. To help the family achieve their weight loss and physical activity goals, counsel the family to also decrease sedentary behavior, such as television viewing and other forms of screen time, to less than 2 hours per day.⁴

Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at <http://www.dshs.state.tx.us/thsteps/providers.shtm>.

AGE	History	Nutritional Screening	MENTAL HEALTH		TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	MEASUREMENTS				VISION		HEARING		Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	LABORATORY TESTS				Health Education/Anticipatory Guidance
			Mental Health: Psychosocial/ Behavioral Health Screening	PSC-17, PSC-35, Y-PSC, PHQ-9, PHQ-A, ORAFFT, or Patient Health Questionnaire for Adolescents			Height	Weight	BMI	Blood Pressure	Visual Acuity	Subjective Vision	Audiometric Screening	Subjective Hearing			Dyslipidemia	Type 2 Diabetes	STD/STI Screening	HIV Test	
11	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
12	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
13	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
14	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
15	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
16	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
17	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
18	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
19	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
20	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory

LEGEND	
	Mandatory
	If not completed at the required age, must be completed at the first opportunity if age appropriate.
	For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.
	Recommended
	Risk-based

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: <http://www.dshs.texas.gov/thsteps/Texas-Health-Steps-Checkup-Components/>. For free online provider education: txhealthsteps.com.

