DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

7 June 2006

MEMORANDUM FOR SEE DISTRIBUTION

FROM: HQ USAF/SGO
110 Luke Avenue, Room 400
Bolling AFB DC 20032-7050

SUBJECT: Vaccine Policy and Guidance for Adults and Accessions

Recent changes to the Center for Disease Control and Prevention's (CDC) recommendations for adult vaccinations have resulted in the need to clarify AF vaccine policy for all adults and our vaccination processes for accessions. Effective immediately, all accessions will meet the vaccination requirements as described in the attachment. Variations to this accession vaccination/testing policy will be coordinated with AF/SGOP prior to implementation.

Two new vaccines were added to the CDC's Adult Immunization Schedule in October 2005: MMR (measles, mumps, rubella) and varicella (http://www.cdc.gov/nip/recs/adult-schedule.htm). Although the recommendations to use the Tdap vaccine in adults are still provisional, pending publication by the CDC, the AF is implementing those recommendations at this time to expedite vaccination of healthcare and child daycare workers (http://www.cdc.gov/nip/vaccine/tdap/tdap_adult_recs.pdf).

All who require these new vaccinations will be identified in Air Force Complete Immunization Tracking Application (AFCITA). For Active Duty, these new requirements will affect Individual Medical Readiness status but will be given a phase-in (YELLOW) period of one year from the date of this memo. After that time, failure to meet these new requirements will result in a "not medically ready" (RED) status.

My POC for this memorandum is Col Michael Snedecor, AFMOA/SGPP, 110 Luke Avenue, Room 405, Bolling AFB, DC 20032, (202) 767-4260, or email: michael.snedecor@pentagon.af.mil.

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Attachment:
Updated Vaccine Guidance

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Updated Vaccine Guidance for Adults and Accessions—June 2006

Unless superseded by Air Force or DoD policy, follow guidance in package inserts and from the Centers for Disease Control and Prevention (CDC), which formally publishes recommendations from the Advisory Committee for Immunization Practice (ACIP), for the administration of vaccines. Note that many vaccine manufacturers consider childhood to continue through age 18.

ADULT VACCINATIONS

The following guidelines can be complex to understand. This complexity will be programmed into the Air Force Complete Immunization Tracking System (AFCITA), the AF's electronic tracking system, which will provide prompts for required vaccinations. When in doubt, refer to the CDC published guidelines or contact your higher headquarters for clarification.

MMR

Mumps Component

Active duty members without direct proof of mumps immunity or vaccination or provider-documented history of mumps but either 1) tested serologically positive for either measles or rubella (such as at accessions) or 2) have proof of vaccination to measles or rubella (but not mumps) will not be required to be vaccinated or serologically tested for mumps. Members without proof of mumps immunity or vaccination or history of mumps and who were not serologically tested or vaccinated for measles and rubella must be vaccinated with MMR according to ACIP guidelines. Members born prior to1957 do not require vaccination.

Healthcare workers and volunteers born after 1956 without proof of immunity, disease or history of two lifetime MMR vaccinations will be vaccinated per ACIP guidelines (two MMR vaccinations). Those born prior to 1957 do not require vaccination, but may be offered MMR if desired.

Measles, Rubella Component

All active duty members without documented proof of immunity, vaccination or provider-documented history of disease should be vaccinated with MMR per ACIP guidelines.

All adult beneficiaries born after 1956 should be offered MMR according ACIP guidelines (http://www.cdc.gov/nip/recs/adult-schedule.htm).

Varicella

Active duty members without evidence of immunity will be vaccinated per ACIP guidelines. Evidence of immunity includes: 1) serological proof of immunity, 2) documented, age-appropriate proof of vaccination (see ACIP definitions), 3) history of varicella based on personal

or provider-documented report of typical varicella disease (see ACIP definitions); 4) born in the US before 1966 and 5) provider-documented history of herpes zoster. See ACIP sources for a more complete definition (http://www.cdc.gov/nip/recs/adult-schedule.htm). Acceptable evidence of immunity will be documented appropriately in AFCITA.

All healthcare and child daycare workers and volunteers without evidence of immunity must be vaccinated per ACIP guidelines as above.

Adult beneficiaries without evidence of immunity or vaccination should be offered vaccination, especially those who 1) have close contact with persons at high risk for severe disease (healthcare workers and family contacts of immunocompromised persons) or 2) are at high risk for exposure or transmission (e.g. teachers of young children; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).

Tdap

All healthcare and child daycare workers and volunteers will be vaccinated with Tdap when it has been at least two years since their last Td vaccination. Those with contact with patients and/or children should be prioritized to receive Tdap as soon as practical.

Active duty member will receive Tdap for their next scheduled dose of Td.

Other indications for Tdap use should follow provisional ACIP guidelines until final CDC guidelines are published.

ACCESSION VACCINATIONS

Clustering or Staging Vaccinations

Accessions often require multiple vaccinations when entering military service, especially when prior vaccination history is unavailable or cannot be utilized. The Armed Forces Epidemiological Board (AFEB) (http://www.ha.osd.mil/afeb/2004/2004-04.pdf), the CDC, the Institute of Medicine and other authorities state that multiple, concurrent vaccination has not been associated with serious health risks. The AFEB recommends that concurrent administration be spread out over time when possible. They and the soon-to-be-published Armed Forces Joint Instruction 48-110, *Immunizations and Chemoprophylaxis*, recommend two clusters consisting of a first cluster of vaccinations against immediate threats during accession training and a second cluster of those that can be delayed until later in training. When possible, all vaccinations should be completed prior to any field deployment and no later than arrival at the first duty station.

Pregnancy testing is often conducted upon accession inprocessing but is not required prior to vaccination per AFJI 48-110 or CDC guidance. If pregnancy testing is conducted, live virus

vaccination in the first cluster should be deferred until the results are known. If pregnancy testing is not conducted, follow screening guidelines IAW AFJI 48-110.

First cluster vaccinations should include influenza, adenovirus (when available), meningococcal, measles, mumps, rubella (MMR), tetanus, diphtheria, pertussis (Tdap) and varicella vaccines. Second cluster vaccines should include inactivated polio and hepatitis A and B vaccines.

First cluster vaccinations should be completed or the primary series started no later then the second week after reporting for accession training. Regardless of whether serology or immunization record review is used to determine vaccination status, these must be done no later than the second week of training. This will provide vaccine to the non-vaccinated/non-immune and the results will be entered into AFCITA.

For direct accessions, vaccinations can be completed in clusters but all single vaccinations should be completed and all series vaccinations should be started no later than two months after arrival at the first duty station.

Influenza

Influenza vaccine will be given as long as it is available and unexpired. FluMist is the preferred vaccine due to its increased efficacy and cross-coverage of influenza strains compared to the inactivated vaccine. It must be stored and used as directed by the package insert. Concurrent administration with other live virus vaccines is approved; otherwise FluMist must be separated from other live virus vaccines by 28 days or as directed by the package insert. However, inactivated vaccine may be used if logistics or other factors make using FluMist less desirable. Other vaccines are to be used as directed by the package insert. Vaccinate in the first cluster if clustering is used.

Meningococcal

Meningococcal vaccine, preferably MCV4 (Menactra), will be given unless proof of vaccination with MCV4 is obtained. If prior vaccination with MPSV4 (Menomune) occurred more than 2 years prior, revaccinate with MCV4. Vaccinate in the first cluster if clustering is used.

Measles, Mumps, Rubella

Accessions will be tested serologically for measles, mumps and rubella immunity unless immunization records are available and age-appropriate vaccinations are transcribed into AFCITA. Two MMR vaccinations, given anytime in the past, are required. Provider-documented proof of disease is also acceptable and must be transcribed into AFCITA. If any component is lacking (immunity, proof of 2 age-appropriate vaccinations or disease), vaccinate with MMR per ACIP guidelines. Vaccinate in the first cluster if clustering is used.

Varicella

Accessions will be tested serologically for varicella immunity unless immunization records are available and age-appropriate vaccinations are transcribed into AFCITA. Personal history or provider-documented proof of typical varicella disease are also acceptable and must be transcribed into AFCITA. If immunity, proof of vaccination or disease is lacking, vaccinate with varicella vaccine per ACIP guidelines. Vaccinate in the first cluster if clustering is used.

Tetanus, Diphtheria, Acellular Pertussis

Accessions will be vaccinated with Tdap vaccine unless their last Td vaccine was less than 2 years prior as documented by immunization records. If immunization records are unavailable, immunize with Tdap. Tdap vaccination should occur in the first cluster to provide protection against pertussis in the training environment.

Inactivated Polio

Per Health Affairs Policy 99-029, *Policy for the Use of Inactivated Poliovirus Vaccine*, 22 Oct 1999, accessions will be vaccinated using inactivate polio vaccine (IPV) to provide a booster unless vaccinated as an adult. IPV may be deferred to the second cluster of vaccinations if desired.

Hepatitis A

Accession sites may either test accessions for hepatitis A serological immunity or defer vaccination until hepatitis B serological status is determined. This will allow either vaccination with mono-vaccine hepatitis A or combined hepatitis A and B vaccine according to ACIP guidelines. Review and transcription of immunization records into AFCITA are acceptable as well. Hepatitis A may be deferred to the second cluster of vaccinations if desired.

Hepatitis B

Accessions will be serologically tested for hepatitis B immunity unless vaccination records show proof of immunity or vaccination and the results are transcribed into AFCITA. Those without immunity or history of vaccination will be vaccinated against hepatitis B according to ACIP guidelines. This can be deferred to the second cluster of vaccinations if desired.