

Patient specific direction (PSD) for the instruction to administer the low-dose diphtheria, tetanus and inactivated poliomyelitis vaccine (Td/IPV) vaccine to children aged between 6 and under 10 years old by trained vaccinators at East London NHS Foundation Trust (ELFT) Vaccination Centre

Recipient details:				
First Name		Surname		
NHS Number		Date of Birth		Age

Patient assessment to receive Td/IPV vaccination in accordance with UKHSA Immunisation against infectious disease (Green Book) Chapter 26 and Joint Committee on Vaccination and Immunisation (JCVI) recommendations for the management of cases and contacts of polio in an outbreak.

Eligibility Criteria – For children aged 6 years to less than 10 years old		Action
<input type="checkbox"/>	Full (3 doses) primary course of polio containing vaccine AND pre-school booster (dTap/IPV) more than 12 months ago	Eligible for booster vaccination
<input type="checkbox"/>	Full (3 doses) primary course of polio containing vaccine AND pre-school booster (dTap/IPV) less than 12 months ago	No additional vaccination required
<input type="checkbox"/>	Full (3 doses) primary course of polio containing vaccine but NO pre-school booster (dTap/IPV)	Please signpost to GP surgery so can receive pre-school booster (Boostrix-IPV)
<input type="checkbox"/>	Unimmunised, incomplete primary course, unknown or uncertain history	Please signpost to GP surgery so can receive catch up primary course (hexavalent vaccine)

Criteria	Answer
1. Has the recipient ever had a confirmed anaphylactic reaction to a previous dose of diphtheria, tetanus or poliomyelitis containing vaccine, including any conjugate vaccines where diphtheria or tetanus toxoid is used in the conjugate?	<input type="checkbox"/> No – Proceed to next question
	<input type="checkbox"/> Yes - Vaccination contraindicated
2. Has the recipient ever had had a confirmed anaphylactic reaction to any component of the vaccine, including neomycin, streptomycin or polymyxin B?	<input type="checkbox"/> No – Proceed to next question
	<input type="checkbox"/> Yes - Vaccination contraindicated
3. Is the recipient currently suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for immunisation)?	<input type="checkbox"/> No – Proceed to next question
	<input type="checkbox"/> Yes - Defer vaccination until recovery from acute illness. If unsure, requires discussion with prescriber
4. Does the recipient have an unstable neurological condition?	<input type="checkbox"/> No – Proceed to next question
	<input type="checkbox"/> Yes - Requires a risk/benefit discussion with prescriber
5. Has the recipient previously experienced a neurological episode within 7 days after receiving a vaccine?	<input type="checkbox"/> No – Proceed to next question
	<input checked="" type="checkbox"/> Yes - Requires a discussion with the prescriber. If the child has not been investigated by a specialist, then vaccine should be deferred until fully investigated
6. Is the recipient taking any anticoagulant medication or have a bleeding disorder or thrombocytopenia (low platelet count)?	<input type="checkbox"/> No – Proceed to next question
	<input type="checkbox"/> Yes - Discussion with prescriber. Advise applying pressure to injection site for 2 minutes following vaccination. (If on Warfarin – ensure INR is in range (refer to Green Book)

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Recipient / Parent / Carer / Legal Guardian Agreement To Vaccination:		
The recipient / parent / carer / legal guardian has received and read the relevant information leaflets and agrees to receive the vaccination	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The recipient / parent / carer / legal guardian wishes to receive more information from a clinician before proceeding further	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Name of parent / carer / legal guardian:		
Relationship to the recipient:		

Details of person undertaking screening:			
Name		Signature	Date

Authorising prescriber consent decision & details:			
I am satisfied that the recipient (or their nominated legal representative) has received all of the relevant information from the Screener or UKHSA and has provided consent to receive the vaccination.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
I have discussed the recipient / parent / carer / legal guardian's concerns (or provided more information) and the recipient decision for vaccination is to:	Consent <input type="checkbox"/>	Decline <input type="checkbox"/>	N/A <input type="checkbox"/>
Suitable for immunisation <input type="checkbox"/>	Immunisation contraindicated <input type="checkbox"/>	Immunisation deferred <input type="checkbox"/>	

Authorising Prescriber Details (PSD valid for 7 days from prescriber signature):			
Name/Surname:		Date:	
Signature:		Professional Registration Body & Number:	

Vaccine administration to be recorded on CarePlus

Administration section below to be used during CarePlus downtime only:

Vaccine:	Site:	Batch No:	Expiry:
REVAXIS (Td/IPV) 0.5mL by intramuscular injection	<input type="checkbox"/> Left deltoid <input type="checkbox"/> Right deltoid		
Administered by (Name & Surname):	Signature	Date and Time of administration:	