

Guidance for School-located H1N1 Vaccination Planning

Provided by the West Virginia Department of Health and Human Resources
And
The West Virginia Department of Education
September 2009

Introduction

The following guidance and information is provided for planning purposes. It is based on the best available information at the time this document was developed. Please note that some of the information below is subject to change. For the latest information, please contact your local health department, the WV Bureau for Public Health, or the WV Department of Education, Office of Healthy Schools. In addition, CDC is anticipated to soon release guidance and tools related to planning school-located vaccination clinics. This document will be adapted accordingly, as needed, to be consistent with federal guidance and tools as they are released.

Purpose: To provide guidance for planning and conducting 2009 H1N1 influenza vaccination clinics targeting school-aged children enrolled in school and potentially other groups in the community.

Target audience: Primarily, local health department (LHD) immunization and preparedness staff responsible for carrying out or overseeing 2009 H1N1 vaccination efforts and county public, private, and parochial school system staff responsible for ensuring parents/guardians are provided with information and access to voluntary H1N1 vaccination clinics.

Glossary:

LAIV – live, attenuated influenza vaccine

LHD – Local health departments

SLV – School-located vaccination

TIV – Trivalent inactivated vaccine

WVDE – West Virginia Department of Education

WVDHHR – West Virginia Department of Health and Human Resources

WVSIIS – West Virginia Statewide Immunization Information System

Background:

The first available doses of the 2009 H1N1 influenza (sometimes called “novel H1N1” or “swine flu”) vaccine are anticipated by October. The Advisory Committee on Immunization Practices (ACIP) has recommended that people ages 6 months to 24 years; pregnant women; people ages 25-64 years who have certain medical conditions, such as heart or lung disease, diabetes, weakened immune systems, blood disorders, neurologic or neuromuscular disease, and other illnesses; parents and caregivers of children less than 6 months of age; and healthcare workers and emergency medical services personnel be considered the highest priority groups for initial vaccination (see: <http://www.cdc.gov/h1n1flu/vaccination/acip.htm>). The priority age group includes school-aged children, who are generally ages 5-18 years. Of course, the ACIP continues to recommend annual seasonal influenza for all children, 6 months through 18 years of age (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e0724a1.htm>).

Private providers (e.g., pediatricians) are unlikely to serve as the primary vaccinators of school-aged children because they cannot quickly vaccinate large numbers of children in a short period of time (Rand, 2008). In addition, children of this age infrequently access health care for preventive, non-acute care so many extra medical care visits would be required to vaccinate children in traditional provider settings (Rand, 2007). As an alternative, SLV has been widely discussed as a potentially viable option for vaccinating many school-aged children against 2009 H1N1 in a short period of time and may also be a way to reach others for vaccination. There are benefits to holding 2009 H1N1 SLV clinics:

- Large numbers of children are found in schools
- Schools are conveniently located throughout communities
- Communities are generally familiar with and trust schools
- School facilities can generally accommodate mass vaccination clinics (e.g., the availability of gymnasiums and auditoriums, ample parking in some locations)
- School nurses, if present, may be available to assist in vaccination activities and may be familiar with the health of individual students
- School staff have access to parental contact information, which could facilitate communications (e.g., for announcing clinic dates, obtaining parental consent for vaccination)
- Others prioritized for vaccination besides enrolled students may request vaccination at vaccination events

There are also potential challenges to holding 2009 H1N1 SLV clinics:

- Clinics could disrupt educational activities
- Locating adequate staff to prepare for and conduct the clinic may be difficult
- Immunization activities may need to be tailored to each school or school district, complicating planning efforts
- Handling and transporting the vaccine to many and varied locations requires considerable planning, equipment, and training

Many schools and public health departments have conducted SLV clinics in the past, but many have not. The planning guide below, as well as the links to guidance developed by other groups (e.g., the National Association of County and City Health Officials [NACCHO] School-located Influenza Immunization School Kit, <http://www.naccho.org/toolbox/tool.cfm?id=1680>), has been designed primarily to help inexperienced but interested LHD, schools/school districts, and others conduct successful 2009 H1N1 SLV clinics. Of course, the decision about whether or not to pursue SLV clinics should be made at the local level, since the feasibility of holding these clinics will vary greatly by local health department, school district, and even every individual school.

This planning guide, for the most part, assumes that the LHD will be leading the 2009 H1N1 SLV effort. The guide focuses on vaccinating enrolled students because of the many unique challenges when SLV occurs during school hours. However, options for vaccinating other persons also are mentioned. For planners who are considering the school as a potential venue to offer vaccines primarily to non-students, general guidelines for setting up large-scale vaccination clinics are posted on the CDC H1N1 website (<http://www.cdc.gov/h1n1flu/vaccination/statelocal/settingupclinics.htm>).

West Virginia Specific Guiding Principles & Planning Assumptions for H1N1 Vaccination

Guiding Principles for Planning Purposes:

The LHD will serve as the lead on H1N1 vaccine distribution and use within the community. In planning for vaccination clinics, all planning parties must work collaboratively with the LHD to determine the best strategies for getting school age children in the community vaccinated. Through the partnership and coordination of the LHD, the key planning partners will be able to assist with public education/information campaigns, administration of community/private/school-located vaccination clinics and other pertinent avenues offering education and vaccination availability. The goal should be to ensure that priority populations, including school-age children, are provided with avenues to voluntarily access the H1N1 vaccination within their community. The array of strategies is unlimited and should be developed based on many factors. These factors include but are not limited to:

- availability of vaccine elsewhere in the community
- child access to other community-based vaccination sites
- level of disease in the community
- presence of individuals at high risk for flu complications in the school setting
- feasibility of offering vaccine in the school setting
- availability of health sector partners to support such efforts
- parent interest

Planning principles include but are not limited to the following:

- Novel H1N1 Flu Vaccination is voluntary and vaccines will only be administered following receipt of informed consent from the individual or their legal guardian.
- Children/staff at high risk of complications of H1N1 flu should be encouraged to access vaccine through available avenues in the community, as soon as it is available, as opposed to waiting for school-located clinics to be organized.
- County school systems can assist in the identification of priority school populations to target within the planned strategies and consideration factors. Programming has been developed through WVEIS to assist public school systems in pulling existing system information needed to assist county vaccination planning teams in making these decisions. Please access this tool at <https://wveis.k12.wv.us/nclb/private/nclbdata09/h1n1p.cfm?cn=099>.
- Decisions about holding school-located vaccination efforts are local decisions.
 - It is assumed that every county will consider, in conjunction with their LHD, providing vaccine through the school setting; however, it is not assumed that such will be implemented in every county.
 - If a school-located program of vaccination is implemented in a county, it does not imply that a clinic must be held in every school/with every school community in a jurisdiction. Again, a variety of factors go into these decisions.
- School-located vaccination programs will be undertaken in partnership with an existing healthcare sector partner familiar with administering pediatric immunizations. All health professionals who administer vaccines will be licensed to do so and experienced.

- Standard medical records will be maintained by the health provider assisting the school with vaccination.
- Although adverse events are expected to be rare, providers working with school settings to administer vaccine should be available to assist in management of any identified vaccine adverse events that arise.
- Consideration may be given to including individuals other than students through school-located vaccine efforts (e.g., staff, parents, family members, etc.); however, expansions beyond students should not exceed vaccine target groups being promoted on a community wide basis at the time the school-located effort is being undertaken.

The LHD and its planning partners can develop multiple models to address the considerations mentioned above. The chosen model(s) should reflect the needs and resources of the local district to ensure that the target population is provided with opportunity for education and access to vaccination. Some sample strategies for increasing vaccination of school age children include one or many varieties of the following:

- Use of the school as a communication channel – sharing information on flu and H1N1 vaccine, linking individuals in the school community to where vaccine is available in their community, promoting vaccine, etc.
- Working with a variety of community partners (LHD, primary care center, hospital, commercial vaccination provider, or others) to provide medical direction and staffing of vaccination clinics held specifically for the school population. Such clinics can be undertaken with a variety of community based partners. In addition, there are a variety of models by which this can be done:
 - Holding a vaccination clinic in the school setting, after school hours, for the school community.
 - Holding a vaccination clinic during school hours with parents present.
 - Holding a vaccination clinic during school hours with parents sending in informed consent in advance.
 - Working through a school based health center to provide ongoing vaccine services in the school setting.
 - Working with a local provider willing to accept school based referrals of children and staff at high risk of complications from influenza and supporting delivery of the same.
 - Combined strategies are also feasible in various school settings (e.g., an initial large scale clinic followed by provision of ongoing vaccines through the school based health center, etc.).
 - Other models.
- Coordinating or integrating efforts among schools: working in feeder school clusters, incorporating private or parochial school student vaccination into public school vaccination programs or vice versa, reaching out to home-schooled students, etc.

Regardless of approach, these guiding principles should be used to develop specific plans for your facility/jurisdiction.

General Planning Assumptions:

- Barring unforeseen circumstances, an H1N1 vaccine program will be undertaken in the fall of 2009.
- Target groups for H1N1 vaccine will be determined by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) and West Virginia will follow these recommendations. Targeted groups will include all school age children.
- Vaccine will first be made available through networks of provider sites (both public and private) where individuals at high risk of H1N1 complications can seek vaccine. While hopefully initiated early in the vaccine effort, school-located vaccination efforts will likely not be the first venue through which vaccine is available to very high risk individuals.
- Large vaccination initiatives aimed at specific target groups in a common setting (e.g., school-located clinics, etc.) will be initiated after vaccine is disseminated to public and private provider offices, as sufficient supplies of vaccine are available and as such events can be well planned.
- It is assumed that the primary target group of school-located vaccination efforts is school children. However, where appropriate and feasible, consideration may be given to offering vaccine to others associated with the school setting (e.g., staff, parents, family members, broader community members). For example, school-located vaccine clinics may target
 - Students only
 - Staff, parents, family members, community members who fall into targeted high risk groups
 - All staff, parents, family members, community members
- Decisions on this topic should be made in conjunction with the LHD at the time of planning individual clinics/efforts.
- Issues to consider when making this decision should include:
 - Available vaccine supply (for school-located clinic and in broader community)
 - Availability of other vaccination venues in community where vaccine can be accessed
 - Who vaccine is being promoted for at the time (just target groups at high risk or for anyone who wants it)
 - Level to which it's felt targeted high risk groups in the community have been reached/obtained vaccine if they want it
 - Feasibility of opening effort up to non students [e.g., capability of provider(s) undertaking clinic; time available; supplies available, etc.]
- All vaccines given through the school setting will be entered into the WV Statewide Immunization Information System (WVSIIS) to assure:
 - Tracking of vaccine use/doses administered
 - Accurate reporting of adverse events/vaccine recall capabilities, if needed
 - Delivery of a second dose, if applicable, whether such be through the school or other settings
 - Information for management of school-located outbreaks, should they occur after vaccinations begin

Vaccine Timing, Distribution, and Associated Supplies:

- The LHD will be the lead agency within each county to develop and administer the vaccination distribution plan as vaccine becomes available. All planning information related to vaccine distribution will be provided by the LHD.
- Distribution of H1N1 vaccines is expected to begin by Mid-October.
- Initial doses are expected to be primarily in the form of LAIV (intranasal vaccine – preferred for healthy children and adults ages 2 through 49 years) and some formulations of preservative-free injectable vaccine (pre-filled syringes of dosage applicable to individuals ≥ 5 years of age; some prefer this product during pregnancy given it is preservative-free). Available formulations will change over time with an increasing supply of multi-dose vials.
- For planning purposes, assume that SLV clinics, where held, would begin in late October/early November. (This could vary either way depending on the time and volume of vaccine made available).
- Vaccine will be fully federally purchased and provided without cost to vaccine administrators through public health. Vaccine will not be commercially available (at least for the first several months). All vaccine for SLV clinics will be obtained through the LHD (even if provided in partnership with another vaccination provider).
- Vaccine will come with the following supplies: syringes, needles, alcohol wipes, sharps containers, and individual vaccination cards. Other supplies will need to be obtained locally.

Financing

- Private providers may charge a fee for vaccine administration as allowed by standard third party payers. (They cannot charge for the vaccine itself).
- Public providers will likely utilize implementation funds as their primary source of funding to cover administrative expenses. (Public providers may also be allowed to charge an administrative fee of third party payers, but this is not yet determined).

Vaccine Formulation and Administration

- Vaccine is being manufactured through 5 different companies (4 as injectable, 1 formulation as a live attenuated virus nasal spray - LAIV). Directions will be specific to the manufacturer of each vaccine.
- Noting the importance of both seasonal and H1N1 vaccination, administration of inactivated seasonal and inactivated H1N1 vaccination (injectable) may be given simultaneously in separate anatomical sites. Note LAIV (live attenuated) seasonal and LAIV H1N1 vaccinations (each given intranasally) may not be given simultaneously.
- The majority of vaccine for school-located initiatives will be in multi-dose vials, although some LAIV will also be available and may be an option.
- It is not yet known whether one dose or two will be necessary (pending outcome of clinical trials). If two doses are needed, planners should assume doses are separated by 21 – 28 days. Initial vaccine is not expected to contain an adjuvant. It is possible that subsequently obtained vaccine will utilize an adjuvant (outcomes of clinical trials pending). If an adjuvant is used, formulations will likely vary by manufacturer. For at least one manufacturer, vaccine may be pre-formulated with adjuvant. For the other three injectable vaccines, adjuvant would need to be mixed with vaccine at the time of vaccine administration. The Medimmune product (intranasal spray) will not be adjuvanted.

Liability Concerns

- There are several mechanisms through which liability concerns are addressed for vaccine providers and others assisting with this effort. These include:
 - The federal PREP Act provides immunity to liability for licensed healthcare professionals involved in the administration of H1N1 vaccine under the HHS Secretary’s Declaration (see website: <http://www.hhs.gov/disasters/discussion/planners/prepact/index.html>). The federal PREP Act also authorizes an emergency fund in the United States Treasury to provide compensation for injuries directly caused by administration or use of a countermeasure covered by the Secretary’s declaration. Assuming funds are appropriated for this purpose, if needed, compensation may then be available for medical benefits, lost wages and death benefits to individuals for specified injuries.
 - If the clinic is undertaken in conjunction with the LHD, the school health professional can participate as a volunteer through the local health department (if officially signed up as such). Local health volunteers are covered under the LHD’s liability protection to the same extent as their employees (see your LHD for specifics), or
 - Finally, it is likely that state code applicable to “duly qualified emergency service workers” (Chapter 15-5-11) applies to coverage of LHD Health and Medical Volunteer Groups. This state code grants immunity from civil suit for volunteers serving under the direction of a state or local governmental entity in training for or responding to an actual or pending emergency.
- All health professionals volunteering to assist with vaccination administration should be properly trained, appropriately licensed, and experienced to ensure competency and safety.
- However liability coverage is provided, the licensed school health professional should be operating within the scope of practice for their health professional license, should be experienced in the role they undertake, and should receive vaccination training from the LHD or onsite medical provider prior to the vaccination clinics to ensure competency and safety.

Vaccine Tracking

- Vaccine administered through school-located clinics will be tracked.
- Tracking will be through WVSIS and will require direct internet based data entry, or if internet access is not available, data entry via thumb drive version of software for subsequent secure data upload into WVSIS.

Adverse Event Reporting

- The Vaccine Adverse Event Reporting System (VAERS), an existing national vaccine safety surveillance program co-sponsored by the Centers for Disease Control and Prevention and the U.S. Food and Drug Administration (FDA), will serve as the foundation for safety monitoring.

Additional Considerations

Clinic Logistics

- LHDs have had significant experience in setting up large scale vaccination clinics and may have information to offer related to maximizing clinic flow, troubleshooting problems, etc.
- Private sector vaccination providers should incorporate a plan to cover the administrative fees for uninsured populations.
- The option of flu mist or injectable vaccine at SLV clinics will impact many planning variables.
- Pre-vaccination information for students and parents/guardians should include explanations of vaccinations recommendations, dates of both H1N1 vaccination clinics, if two doses are required, consent process, and contact phone numbers for pre and post vaccination clinic questions.
- Protocols must include instructions for managing situations when children with parent consent refuse the vaccination during the clinic without parent/guardian present.
- Planning must include logistics for second dose clinics, including but not limited to, second dose consents being obtain within the 21-28 day waiting period between doses, patients requesting a first dose during the second dose clinic, patients requesting a second dose via a route different than the first administered dose, etc.
- Pre-vaccination information for students and parents/guardians must include notification related to actions for onsite adverse reactions, comfort measures available onsite (non-pharmaceutical or pharmaceutical), providing contact information and numbers for pre and post vaccination clinic questions, etc.
- Planning should incorporate the possibilities of student and parent requests for comfort needs post-vaccination and services outside of the scope of school health services (i.e. OTCs, prescriber ordered care).
- Elementary SLV clinics may be best administered at the end of the school day to allow parent/guardian participation in routine and post vaccination care of intramuscular injections.
- Availability of vaccination consent forms online, either web-based or emailed through parent or parent association listservs.
- Identifying a single spokesperson and providing information on their websites.
- Planning should include educating all school staff about the vaccination clinics and where to direct more complex questions.

Legal Issues:

- HIPAA: Reporting administration of childhood vaccination to public health and the immunization registry is required under state law. It is not a HIPAA violation and does not require separate parental consent; however, you should share with parents that you will be entering data into this system. This system enables vaccine doses to be tracked, supports monitoring for vaccine safety, enables better recalls for second doses, assures good information on vaccinated students when managing outbreaks, etc.
- SLV planning partners may choose to establish a memorandum of understanding (MOU) or a similar document between LHD, school systems and other partners involved in the SLV. Include use of school facilities; roles and responsibilities of all parties; consent process; responses to various reactions; follow-up with students, parents/guardians; etc.

Other:

- The healthcare provider (LHD, PCC, hospital, etc.) helping oversee the SLV clinic should arrange for someone to be available for after hour calls for questions on the vaccine, evaluation of any potential adverse events, etc.

- West Virginia Public Schools must work closely with LHD to ensure understanding and planning for disease reporting, as outlined in West Virginia laws (W.Va. Code §16-3-1 and West Virginia Department of Health and Human Resources Rule 64 CSR 7). The applicability of WV Rule 64CSR7 includes school administrators (schools) to report influenza-like illnesses (ILI), novel influenza infection and a host of other reportable diseases. The WV Reportable Disease Manual is located at <http://www.wvdep.org/WVReportableDiseaseManual/tabid/1435/Default.aspx>.

Additional Resources

The Centers for Disease Control and Prevention (CDC) will be publishing guidance on H1N1 School-located Vaccination Clinics and sample consents in the near future. These will be accessible from the www.flu.gov website. While the guidance from WVDE and WVDHHR is being release in advance to assist with current planning, the future CDC guidance should also be reviewed and consulted. Any discrepancies should be reviewed with your local health department, WVDE, or WVDHHR.

Centers for Disease Control and Prevention (CDC). (2009). *Checklist for Safe Vaccine Handling and Storage*. Retrieved from <http://www.immunize.org/catg.d/p3035.pdf>.

Centers for Disease Control and Prevention (CDC)-Guidelines for Setting up Clinics. (2009). Retrieved from <http://www.cdc.gov/h1n1flu/vaccination/statelocal/settingupclinics.htm>. **(Please note number 3 of the CDC-Guidelines for Large Scale Novel H1N1 Influenza Vaccination Clinics is not relevant to most vaccination providers/administrators, as they have their own provider for authorization and standing orders).**

Centers for Disease Control and Prevention (CDC). (2009). *Novel H1N1 flu (Swine flu: Resources for Child Care Programs, Schools, Colleges, and Universities)*. Retrieved from <http://www.cdc.gov/h1n1flu/schools/>.

J.C. King, Jr., J. J. Stoddard, M.J. Gaglani, K. A. Moore, L. Magder, E. McClure, J. D. Rubin, J.A. Englund, & K. Neuzil. (2006). *New England journal of Medicine*. Effectiveness of School-Based Influenza Vaccinations. 355 (24), pp.2523-2532. Retrieved from <http://content.nejm.org/cgi/content/full/355/24/2523>.

National Association of County and City Health Officials (NACCHO). (2009). *School-Located Influenza Vaccination* webinar. Retrieved from <https://cc.readytalk.com/cc/playback/Playback.do?id=epuhcg>.

National Association of School Nurses. (2009). Retrieved from <http://www.nasn.org/>.

West Virginia Department of Health and Human Resources. (2009). H1N1 website. Retrieved from <http://www.wvdep.org/Home/HotTopicSwineInfluenza/tabid/1856/Default.aspx>.

West Virginia Department of Health and Human Resources. (2008). West Virginia Reportable Disease Rule (64CSR7). Retrieved from <http://www.wvdep.org/LinkClick.aspx?fileticket=a0cnCHjajzg%3d&tabid=1473>.

H1N1 School-located Vaccination Clinic 2009/2010 Planning Schematic Key Partners and Sample Roles

Local Health Department

Lead on H1N1 vaccine distribution and use within the community; lead on working with school systems to develop strategies to increase vaccination of school age children and other target groups, including school based clinics; partner with schools to administer clinics or work in conjunction with the school system to identify other healthcare providers to support implementation of a school based vaccination clinic; participate in determining what groups within the school community will be vaccinated in a school vaccine clinic based on current federal and state guidance on target groups.

School District H1N1 Lead Designee

Work collaboratively with LHD to determine best strategies for getting school children in the community vaccinated; prioritize schools through identifying highest risk students and staff; identify partners to assist with clinics; provide general guidance for school based vaccination clinics; assist local administrator in problem solving administrative questions and concerns related to use of school staff or resources.

Vaccine Administrators for H1N1 School Based Clinics (LHD, Primary Care Centers, Hospitals, Community Providers, etc.)

Provide medical oversight and administration of clinic; collect consents and billing information for first and second clinics; provide vaccine supplies; manage adverse reactions; provide possible comfort measures for OTCs on site with parent consent (tylenol or ibuprofen); provide clinic staff and training for health professionals volunteering to assist with vaccine administration; provide phone number (including after hours) for follow up questions. related to vaccine administration or any potential adverse events.

School Administrator /Nurse

Provide appropriate vaccine clinic location within the school based on detailed guidance; review consents for completion and follow-up as needed prior to clinic; assure a process for accurate student identification; assist vaccine administrator in the identification of additional staff support for clinic.

References:

WVDHHR/WVDE Guidance for School-located H1N1 Vaccination Planning document at: <http://www.wvde.org/Home/HotTopicSwineInfluenza/tabid/1856/Default.aspx> or <http://wvde.state.wv.us/ossdp/main/PandemicFlu.html> and go to the CDC website at <http://www.cdc.gov/h1n1flu/vaccination/statelocal/settingupclinics.htm> for more vaccination clinic planning tools.

***Supplemental Considerations to the
CDC-Outline for Planning and Operating a Large-Scale Influenza Vaccination Clinic for
West Virginia School-located Vaccination Clinics***

This document was developed to incorporate other school site considerations during the planning of school-located H1N1 vaccination clinics. This document will flow with the ***CDC-Outline for Planning and Operating a Large-Scale Influenza Vaccination Clinic*** document at http://www.cdc.gov/h1n1flu/vaccination/pdf/B_Wortley_H1N1_guidelines_vaccination.pdf.

School districts and individual schools should work with their Local Health Department to design the most appropriate approaches to getting school children vaccinated in their community. Specifically related to administering large scale clinics, Local Health Departments across West Virginia have been developing plans for and exercising the running of large scale vaccination clinics for several years now as part of emergency preparedness efforts. Most have developed tools in support of such, learned lessons, devised practical approaches to problem solve identified issues, etc. Schools and any other healthcare providers helping administer school-located clinics should be certain to work with their local health department to tap into that knowledge and to assure that school-located vaccination clinics are done in coordination with broader community efforts and consistent with federal and state guidance related to H1N1 vaccine use at the time the clinic is being offered.

Leadership Roles

- County Superintendent to designate lead H1N1 staff for planning with local health department. Consideration for inclusion of a school nurse if designee is not the school nurse.

Human Resource Needs

- In conjunction with LHD and Lead School District Designee, identify who key partners will be in providing medical direction and administration of clinic (e.g., LHD, other community health care provider, hospital, etc.)
- Develop Memorandum of Understanding (MOU) between school and local health department/onsite vaccine administrator(s). Include use of school facility, roles and responsibilities of all parties, such as vaccine administration, management of allergic reactions, consent, student follow-up, student identification, parent communication, etc.
- With the same group, identify who will provide any staffing support needed (e.g., volunteer groups, LPN/RN nursing or other health profession students and instructors, parents, staff, etc.)
- Consider role of school-located Health Center, if available.
- School nurse(s) to review vaccination consents prior to clinic to ensure completeness and accuracy according to knowledge base of student's health condition(s).
- Student identification name tags and/or school personnel able to properly identify/verify each student prior to vaccination administration.
- Staff to escort students to and from the classroom.
- Licensed school health professionals considering the possibility of assisting the LHD or other onsite medical provider with administration of the H1N1 vaccine can be covered for liability under several possible mechanisms.
 - The federal PREP Act provides immunity to liability for licensed healthcare professionals involved in the administration of H1N1 vaccine under the conditions of the United States Department of Health and Human Services (USHHS) Secretary's Declaration at <http://www.hhs.gov/disasters/discussion/planners/prepact/index.html>.

- If the clinic is undertaken in conjunction with the LHD, the school health professional can participate as a volunteer through the local health department (if officially signed up as such). Local health volunteers are covered under the LHD's liability protection to the same extent as their employees (see your LHD for specifics), or
- West Virginia State Code (Chapter 15-5-11) grants immunity from civil suit (with the exception of willful misconduct) for volunteers serving at the request of a state or local governmental entity in preparation for or response to an actual or pending emergency.
- However liability coverage is provided, the licensed school health professional should be operating within the scope of practice for their health professional license, should be experienced in the role they undertake, and should receive vaccination training from the local health department or onsite medical provider prior to the vaccination clinics to ensure competency and safety.

Vaccination Clinic Location

- Prioritize clinics to schools with increased populations of high risk students and staff using the H1N1 Planning Tool located on the NCLB website.

Clinic Lay-Out and Specifications

- Ensure onsite medical provider plans include daytime and after-hour contact numbers for post-vaccination clinic questions or concerns from students, parents, staff and community participants.
- Ensure onsite medical provider(s) ability to administer prescriber ordered comfort needs of students or per parent/guardian request (i.e. acetaminophen, ibuprofen, etc.).
- Prepare for nonprescription comfort measure needs of students.
- Consider scheduling elementary clinics involving intramuscular injections at the end of the day when parents/guardians can accompany the student. This step will provide the student with accustomed comfort measures usually provided by the parent/guardian during childhood inoculations while providing post-administrative care by the parent/guardian.
- Consider safety issues if making clinic accessible to the community during school hours.
- School-located Vaccination Clinics may not need all the stations addressed in the outline or displayed in the accompanying diagram. Planning should be specific to the needs of each school-located clinic, staffing and populations being targeted.

Crowd Management Inside of the Clinic

- Ensure students who present with consent only (no parent/guardian onsite) are properly identified by name tag or school personnel.

Clinic Advertising

- Use the *CDC-Communication Toolkit for Schools (Grades K-12)* at <http://www.cdc.gov/h1n1flu/schools/toolkit/> for sample letters to schools, teachers and parents/guardians.