



Immunization Protocol: Acknowledgement and Assessment

Please carefully circle or highlight your responses. Please sign and date this document and return it to Triad Care, Inc. via fax (1-336-541-6485) or email (info@triadcare.com).

1. I have received, reviewed, and understand Triad Care, Inc.'s Intramuscular (IM) Injection Protocol. I understand that, if required, I will not administer any injection without a supervising clinician present.
 - a. True
 - b. False

2. I understand that any damaged, ruined, or wasted vaccine doses are to be **returned to Triad Care, Inc.** and should not be discarded by providers.
 - a. True
 - b. False

3. I have read and understand Triad Care, Inc.'s infection control policy for vaccination events.
 - a. True
 - b. False

4. Triad Care, Inc.'s vaccination protocol excludes any patient weighting less than _____ pounds. These patients may not be immunized at a Triad Care, Inc. event.
 - a. 50
 - b. 60
 - c. 65

5. The following are the **ONLY** three absolute contraindications to receiving an inactivated, injectable influenza vaccine at a Triad Care, Inc. event.
 - a. Current antibiotic use, severe anaphylactic reaction to a previous influenza vaccine, pregnancy
 - b. Severe anaphylactic reaction to a previous influenza vaccine, history of Guillain-Barré syndrome, severe illness at time of appointment
 - c. Latex allergy, severe anaphylactic reaction to a previous influenza vaccine, history of Guillain-Barre syndrome

6. I understand if I have any questions regarding protocols or expectations, I should contact my immediate supervisor before I take additional action.
 - a. True
 - b. False

7. Team huddles are mandatory at all onsite vaccination events that are staffed with more than one provider.
 - a. True
 - b. False

8. It is mandatory that the Vaccine Administration Record (VAR) is filled out in its entirety and is signed and dated.
 - a. True
 - b. False

Name: _____

Signature: _____

Date: _____