

Immunization Protocol
Authority to Immunize
Authority to Initiate Immunization
Standing Prescription Order to Administer Immunizations
(Version: 2016a)

Pharmacist Name: _____, ND License # _____, acting as an authorized pharmacist on behalf of the undersigned physician, according to and in compliance with the North Dakota State Pharmacy Practice Act, may administer the immunizations listed below to patients who are at least 11 years old and in addition may administer influenza vaccinations to patients who are at least 5 years old on the premises of:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy City: _____ Zip Code: _____

Pharmacy Phone Number: _____

Email Address: _____

or elsewhere upon notification of sponsoring physician for a time period equal to two years from the date this document is signed.

NDPHA Immunization program (Date of your training program): _____

To protect people from preventable infectious diseases that cause needless death and disease, the above pharmacist may administer the following immunizations to eligible patients, who are at least 11 years old.

- Hepatitis A Vaccine, IM
- Hepatitis B Vaccine, IM
- Human papillomavirus (HPV) Vaccine, IM
- Measles, mumps, rubella (MMR) Vaccine, SC
- Meningococcal conjugate (MCV-4) Vaccine, IM
- Meningococcal group B (MenB) Vaccine, IM
- Pneumococcal polysaccharide (PPSV-23) Vaccine, IM or SC
- Pneumococcal conjugate (PCV13) vaccine, IM
- Tetanus, diphtheria, pertussis (Td/Tdap) Vaccine, IM
- Varicella (chickenpox) Vaccine, SC
- Varicella zoster (shingles) Vaccine, SC

In addition, influenza vaccine (IM and ID) may be administered to those who are at least 5 years old.

All vaccines must be administered according to indications and contraindications recommended in current guidelines from the Advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control and Prevention (CDC) and other competent authorities.

All IM injectable vaccines will be given in the deltoid muscle. All SC injections will be given in the fatty tissue over the triceps muscle. ID influenza vaccine will be administered in the skin near the deltoid muscle.

Other vaccines may be added or deleted from this list by supplementary instruction from the undersigned.

In the course of treating adverse events following immunization, the pharmacist is authorized to administer epinephrine (in the form of an Epi-Pen at 0.3mg per dose) and diphenhydramine (at a dose of 1mg/kg; maximum 50-100 mg per dose) by appropriate routes as necessary. The pharmacist will maintain current certification in CPR.

In the course of immunization, the pharmacy will maintain perpetual records of all the immunizations administered. Before immunization, all vaccine candidates will be questioned regarding contraindications and precautions, such as previous adverse events after immunization, food and drug allergies, current health, immunosuppression, recent receipt of blood or anti-body products, pregnancy, and underlying diseases. All vaccine candidates will be informed of the specific benefits and risks of the vaccine being offered. All vaccine recipients will be observed for a suitable period of time after the immunization for adverse events.

All vaccine recipients will be given an immunization record. The immunization will be reported to the North Dakota Immunization Information System (NDIIS) within 14 days of administration per NDAC 61-04-11-06(1)(b) and NDCC 43-15-01(1)(a)(2).

The pharmacist will not endeavor to disrupt existing patient-physician relationships. The pharmacist will refer patients needing medical consultation to a physician. The pharmacist will make special efforts to identify susceptible people who have not previously been offered immunizations.

The pharmacist shall submit evidence of adequate liability insurance (a claim limit of \$1 million and an aggregate limit of \$3 million) upon signature of this agreement.

The authorization will be valid two years from the date indicated below, unless revoked in writing.

Pharmacist Name: _____

Pharmacist Signature: _____

Pharmacy License #: _____

Date: _____

Physician Name: Terry Dwelle, MD

Physician Signature: _____

Address: 600 East Boulevard Ave. Dept. 301

City: Bismarck State: ND Zip: 58505

Medical License #: 4112

Date: _____

Reminder: Submit evidence of adequate liability insurance.