

**CHAPTER 7**  
**PREVENTIVE MEDICINE**

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**CHAPTER SEVEN – PREVENTIVE MEDICINE****A. General.**

1. **Scope.** The scope of preventive medicine involves all activities that prevent illness and disease, including immunizations; communicable disease control; and epidemiology.
2. **Responsibilities.**
  - a. The unit Medical Officer (MO) is responsible to the Commanding Officer for implementing all directives issued by the Commandant which relate to the health of members of the command. The MO shall:
    - (1) Evaluate the command's health care capabilities to fulfill Occupational Medical Surveillance and Evaluation Program (OMSEP) requirements.
    - (2) Develop and supervise an environmental health program to prevent disease and maintain the Commandant's established sanitation standards.
    - (3) Monitor the incidence of disease or disability in personnel and, when indicated, in adjacent communities.
    - (4) Use epidemiological methods to determine the cause of disease patterns, if there is an increase in incidence.
  - b. Preventive Medicine Technicians (PMTs) are individuals who are highly proficient in all aspects of preventive medicine. If assigned or available to a unit, the unit shall gainfully employ their services.
  - c. The Preventive Medicine (PM) Officer at Commandant (CG-1121) will provide policy recommendations and other consultation as needed to Commandant (CG-11), the HSWL SC, and individual health care providers. The PM Officer will develop evidence-based policies for the control of disease of public health importance and will maintain liaison with civilian and public health (local, State, Federal) and military medical authorities to coordinate appropriate response to public health threats. The PM Officer will also serve as the Public Health Emergency Officer (PHEO) for the CG.



## B. Communicable Disease Control.

1. General. The health services department representative is responsible for complying with Federal, State, and CG communicable disease reporting requirements. In order to have an effective communicable disease control program, health services department representatives should:
  - a. Recognize communicable diseases (see Figures 7-B-1 & 7-B-2).
  - b. Recommend preventive and control measures to the Commanding Officer.
  - c. Submit required reports.
  - d. Comply with state and local health department reporting requirements.
2. Disease Outbreak.
  - a. Definition. An outbreak is defined as two or more linked cases with clinically compatible signs and symptoms of an infection in a given period of time in a specified location or two or more laboratory confirmed cases in a specified location within a given period of time or whatever is above normal in the population specified during a period of time.
  - b. Each clinic and sickbay must have at least one designated staff member responsible for submitting medical event reports (MERs).
  - c. The designated health services department representative shall:
    - (1) Recognize outbreaks and establish a case definition.
    - (2) Investigate the source of the agent and how it spread.
    - (3) Recommend to Commanding Officer appropriate initial control/preventive measures.
    - (4) Complete a Medical Event Report using the Disease Reporting System Internet (DRSi). The Tri-Service Reportable Events document provides detailed definitions of the reportable medical events. The Tri-Service Reportable Events document is located on the Commandant (CG-1121) web page.
    - (5) Contact Commandant (CG-1121) if assistance is needed at any of the aforementioned steps.
    - (6) Follow communicable disease policy guidance disseminated by the HSWL SC and/or Commandant (CG-11) in the event of a bioterrorist threat or a natural or man-made communicable disease threat.
3. Medical Event Reporting.
  - a. Circumstances requiring reports.
    - (1) Any outbreak;
    - (2) Any person diagnosed with any disease listed in Figures 7-B-1 and 7-B-2;

- (3) Any epizootic (e.g. animal epidemic) transmissible from animals to man;
  - (4) Any quarantined CG vessel or aircraft (at a foreign port);
  - (5) Any medical condition deemed worthy of reporting by health services department personnel; or
  - (6) Any reportable medical condition as mandated by the local/state health department.
- b. Reporting Process. CG health services personnel must use the DRSi system for all MERS.
- (1) The NDRSi can be accessed at <https://164.167.138.44/NDRSi/>.
  - (2) For initial access to the NDRSi, the cognizant health services personnel must print out the D System Authorization Access Request , Form DD-2875 and complete Part I of the form and initial Item 27. Health services personnel must have completed the annual mandatory CG Information Systems Security (ISS) Training (which is the CG equivalent to the DoD Annual Information Awareness Training) in order to have DRSi access approved. Part II of the form must be completed by the Senior Health Services Officer (SHSO) or the cognizant Designated Medical Officer Advisor (DMOA). Additional directions for completing and submitting the form can be found on the DRSi website.
  - (3) After completing, the SHSO or DMOA must submit the System Authorization Access Request, Form DD-2875, System Authorization Access Request in hard copy or electronic form to the Navy and Marine Corps Public Health Center (NMCPHC). NMCPHC will contact the individual listed in Part II of the form to verify the request and activate the DRSi user account. NMCPHC will send a Login ID and Password to the user once they obtain the SHSO or DMOA approval.
  - (4) After obtaining a Login ID and password, health services personnel must login to the DRSi. After logging in, directions on how to enter MERS into DRSi can be found by clicking on the “Help” icon. The “Frequently Asked Questions” FAQ link on the Login page also has helpful information.
  - (5) CG units are listed in DRSi by their OPFAC.
  - (6) For any critical conditions listed in Figure 7-B-1, health services personnel must contact Commandant (CG-1121) within 24 hours. Upon final confirmed diagnosis, the health services personnel must enter the medical event report into DRSi. Commandant (CG-1121) will review the information in DRSi and will contact the HSWL SC for all critical conditions.

**Figure 7-B-1  
Medical Event Reporting Chart Within 24 Hours**

**PHONE COMMANDANT (CG-1121) WITHIN 24 HOURS & COMPLETE A MEDICAL EVENT REPORT IN DRST<sup>1</sup>**

Animal Bites	Diphtheria	Influenza Associated Hospitalization	Severe Acute Respiratory Syndrome (SARS)
Anthrax 	<i>E. coli</i> O157:H7	Malaria	Smallpox 
Botulism 	Encephalitis	Measles	Syphilis
Brucellosis 	Foodborne Outbreak	Meningococcal Disease	Tuberculosis 
Carbon Monoxide Poisoning	<i>Haemophilus influenzae</i>	Pertussis	Tularemia
Chemical Agent Exposure	Hantavirus Infection	Plague 	Yellow Fever
Cholera	Heat Illness	Poliomyelitis	Disease Cluster or Outbreak
Cold Weather Injuries <sup>2</sup>	Hemorrhagic Fever 	Q Fever 	
	Hemolytic Uremic Syndrome (HUS)	Rabies	

 *Potential agent of Bioterrorism*

- 1 - HIV, AIDS, Suicide and Occupational Illness / Injury are reported through other mechanisms  
 2 - Frostbite, Immersion Foot, Hypothermia, or other cold injury resulting in a limited duty status.

**Figure 7-B-2  
Medical Event Reporting Chart Within 7 Days**

**COMPLETE A MEDICAL EVENT REPORT IN DRSI WITHIN 7 DAYS**

<b>Amebiasis</b>	<b>Lead Poisoning</b>	<b>Rubella</b>
<b>Campylobacteriosis</b>	<b>Legionellosis</b>	<b>Salmonellosis</b>
<b>Chancroid</b>	<b>Leishmaniasis</b>	<b>Schistosomiasis</b>
<i>Chlamydia trachomatis</i>	<b>Leprosy</b>	<b>Shigellosis</b>
<b>Coccidioidomycosis</b>	<b>Leptospirosis</b>	<b>Streptococcal Disease, Group A</b>
<b>Cryptosporidiosis</b>	<b>Lyme Disease</b>	<b>Tetanus</b>
<b>Cyclosporiasis</b>	<b>Mumps</b>	<b>Toxic Shock Syndrome</b>
<b>Dengue Fever</b>	<b>Norovirus</b>	<b>Trichinosis</b>
<b>Ehrlichiosis</b>	<b>Psittacosis</b>	<b>Trypanosomiasis</b>
<b>Filariasis</b>	<b>Relapsing Fever</b>	<b>Typhoid Fever</b>
<b>Giardiasis</b>	<b>Rheumatic Fever</b>	<b>Typhus Fever</b>
<b>Gonorrhea</b>	<b>Rift Valley Fever</b>	<b>Urethritis (non-gonococcal)</b>
<b>Hepatitis</b>	<b>Rocky Mountain Spotted Fever</b>	<b>Varicella</b>

- (7) Commandant (CG-1121) will review all medical event reports in DRSi on a weekly basis for medical trends and outbreaks.
- (8) For all other MERS there is no need for health services personnel to contact Commandant (CG-1121), the only requirement is to enter MERS that are confirmed and final (no presumptive or preliminary diagnoses should be entered).
4. Sexually Transmitted Infection (STI) Program.
- a. Background. STIs, including the human immunodeficiency virus (HIV) are important and preventable causes of morbidity, mortality and associated lost-productivity and increased health care costs.
- b. Exposure information for non TRICARE beneficiaries.
- c. Exposure information for TRICARE beneficiaries.
- d. Duties of the Health Services Department. Health services department shall provide a coordinated, comprehensive STI control program including:
- (1) Education and prevention counseling of those at risk.
  - (2) Detection of asymptomatically infected individuals.
  - (3) Effective diagnosis and treatment of infected individuals.
  - (4) Partner Services (PS) (formerly known as contact tracing).
  - (5) Immunization of persons at risk for vaccine-preventable STIs.
  - (6) Proper annotation and maintenance of health records.
  - (7) Protection of confidentiality.
- e. Senior Medical Officer (SMO). The SMO oversees the medical management of the local STI control program; recommends STI control activities to the Commanding Officer; establishes and maintains liaison with local health authorities; and ensures confidentiality of the patient and his/her sexual partner(s).
- f. Medical Officer (MO). The MO who initially evaluates the patient shall perform appropriate diagnostic evaluation based on current CDC guidelines. The MO must fill out Syphilis Record, Form SF-602, on all patients diagnosed with syphilis and file the Syphilis Record, Form SF-602, in the patient's medical record. All patients (beneficiaries / active duty / reservists) presenting for evaluation of a possible STI will be tested for serological evidence of syphilis infection. All active duty / reservist presenting for evaluation of a possible STI shall be tested for serological evidence of HIV infection. Additionally all active duty members will be tested for HIV every two years. Reservists are required to have a current HIV test within 2 years of the date called to active duty if the CAD is for 30 days or more. Refer to, Coast Guard Human Immunodeficiency Virus (HIV) Program, COMDINST M6230.9 for more details on the CG's HIV program.

- g. Health Services Technician (HS) or Preventive Medicine Technician (PMT). An HS or PMT assigned to administer the local STI control program should be paygrade E-5 or higher. They shall perform the following actions:

Perform Partner Services (PS): PS is a set of activities intended to alert people exposed to STIs and facilitate appropriate, counseling, testing and treatment. Information about named partners shall be passed to the cognizant local or State public health function for partner notification. Valuable PS and STI resources are available on the internet from the Navy and Marine Corps Public Health Center's, Sexual Health and Responsibility Program (SHARP) at <http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive-sexual-health/Pages/sharp.aspx>.

- (1) Annotate and sign the Chronological Record of Care, SF-600 in each patient's medical record to indicate he or she interviewed the patient, discussed symptoms, complications, treatment, and the importance of partner notification(s).
- (2) Determine whether a Test of Cure (TOC) is indicated for cases of gonorrhea or Chlamydia.
  - (a) Gonorrhea - Patients who have symptoms that persist after treatment should be evaluated by culture for N. gonorrhea, and any gonococci isolated should be tested for antimicrobial susceptibility.
  - (b) Chlamydia - Patients do not need to be retested for Chlamydia after completing treatment with doxycycline or azithromycin, unless symptoms persist or reinfection is suspected. A TOC may be considered 3 weeks after completion with erythromycin.
  - (c) Active duty personnel will report to regular sick call for TOC. Place a suspense notice to check with the attending MO to ensure the patient receives TOC.
  - (d) Dependents and retired personnel will be given regular appointments for local STI treatment.
- (3) Cross reference all positive STI cases from the clinic laboratory log book to ensure all STI patients have been contacted and interviewed. This should be performed on the first work day of each week.
- (4) Ensure security and confidentiality of all STI forms, reports and logs.
- (5) Complete timely reporting. HIV / AIDS (HIV /AIDS reporting must be consistent with the Coast Guard Human Immunodeficiency Virus (HIV) Program, COMDTINST M6230.9 (series). Syphilis, gonorrhea, Chlamydia, and acute cases of hepatitis are reportable events in every state and the CG. The requirements for reporting other STIs differ by State. The National Coalition of

STI Directors website <http://www.ncsddc.org/who-we-are> has links to state specific STI reporting requirements.

5. STI Treatment. MO should treat STIs according to the most current recommendation of the CDC.
6. STI Drug Prophylaxis. Drug prophylaxis for STI prevention is prohibited.
7. STI Immunizations. MO should review the immunization status of all patients presenting with a possible STI. All AD / reservists should receive Hepatitis A and Hepatitis B vaccines (unless vaccine series is complete). Other beneficiaries who seek evaluation for a possible STI should receive Hepatitis A and Hepatitis B if indicated (based on current CDC guidelines).
8. STI Reporting.
  - a. DoD/CG healthcare beneficiaries (TRICARE). Exposure information of DoD/CG healthcare beneficiary partners will be reported via the DRSi as well as to any cognizant State or local health authority) using a State-specific form and process or using CDC Form 73.2936S – Field Record. Forms are available from the CDC at (404) 639-1819. (Local protocol will dictate which specific STI's need to be reported to the state, but all conditions in Figure B-1 and B-2 must be reported via the DRSi system).
  - b. Non-DoD/CG healthcare beneficiaries (NON TRICARE). Exposure information of non-DoD/CG healthcare beneficiary partners will be reported to the cognizant public health authority. Health services personnel should follow local guidance for local reporting of partners. This may entail locally designated forms and procedures. For partners located outside the local area, partner identification information may be sent to the State public health authority (who will forward the report to the cognizant State or local health authority) using a State-specific form and process or using CDC Form 73.2936S – Field Record. Forms are available from the CDC at (404) 639-1819. Health services personnel should not expect confirmation of receipt or a disposition report. If a disposition report is desired, the health services personnel should state this on the Field Record, and provide a statement of justification and return address/phone number.



C. Immunizations and Allergy Immunotherapy (AIT).

1. General. Immunizations and Chemoprophylaxis, COMDTINST M6230.4 (series), lists policy, procedure, and responsibility for immunizations and chemoprophylaxis. This section contains guidelines not specifically defined there. Immunizations for active duty and SELRES shall be documented in Medical Readiness Reporting System (MRRS) and P-GUI/AHLTA as outlined in Chapter 4-C. Vital signs are not required during immunization-only encounters.
2. Unit Responsibilities.
  - a. Immunizing all individuals. Active duty and reserve unit Commanding Officers are responsible for immunizing all individuals under their purview and maintaining appropriate records of these immunizations. If local conditions warrant and pertinent justification supports, HSWL SC may grant authority to deviate from specified immunization procedures on request.
  - b. Unit Commanding Officers. Unit Commanding Officers will arrange local immunizations for their unit's members. If this is not possible, he or she will request assistance from the CG clinic overseeing units in the geographic area.
3. Equipment and Certification Requirement.
  - a. Immunization sites. All immunization sites must have the capability to administer emergency medical care if anaphylaxis or other allergic reactions occur. A designated CG Medical Officer must certify in writing that the registered nurse or HS selected to administer immunizations is qualified to do so because he or she has received instruction and displayed proficiency in these areas:
    - (1) Vaccine dosages.
    - (2) Injection techniques.
    - (3) Recognizing vaccine contraindications.
    - (4) Recognizing and treating allergic and vasovagal reactions resulting from the vaccination process.
    - (5) Proper use of anaphylaxis medications and related equipment (e.g., oxygen, airways).
    - (6) Verification the individual is currently certified in Basic Life Support (BLS).
  - b. Supplies for immunization. The immunization site must have available: syringes with 1:1000 aqueous solution of epinephrine, emergency airways, oxygen, bag valve mask (BVM), and intravenous (IV) fluids with an IV injection set.
4. Immunization Site Responsibilities.
  - a. Where available, a Medical Officer shall be present when routine immunizations are given.

- b. Medical Officer cannot be present. In the event a Medical Officer cannot be present, a registered nurse or HS3 or above can be certified to administer immunizations to AD and SELRES when the following guidelines and procedures are met:
- (1) The designated CG Medical Officer who normally would oversee their independent activity must train and certify in writing registered nurses and HSs conducting immunizations in a Medical Officer's absence.
  - (2) An emergency equipped vehicle must be readily available to transport patients to a nearby (within 10 minutes) health care facility staffed with an Advanced Cardiac Life Support (ACLS), certified physician or an EMS with ACLS capability must be within a 10-minute response time of the site.
  - (3) Hypovolemic shock often is present in cases of anaphylaxis. Therefore medical personnel must be ready and able to restore fluid to the central circulation. In anaphylaxis treatment, epinephrine administration, airway management, summoning help are critical steps toward the treatment of this condition.
- c. Review and document immunizations. All immunizations will be entered in MRRS and documented on the Adult Preventative and Chronic Care Flowsheet, Form DD-2766 by clinic personnel and IDHS. Electronic Health Record entry, Chronological Record of Medical Care, Form SF-600 and Medical Officer cosignature for routine immunizations of Active Duty and SELRES are not required.
- (1) Clinic personnel and IDHS must be cognizant of the use of the proper medical and administrative exemption codes within MRRS. Prior to selecting the exemption code in MRRS, select the information icon. The information icon provides a detailed explanation of the various codes. The cognizant HSA must ensure that all exemption codes are accurate within MRRS. Commandant (CG-1121) will review all medical permanent, medical reactive, medical declined and administrative refusal codes on a quarterly basis. Medical temporary codes and administrative temporary codes must be reviewed and verified by the HSA every 365 days and 90 days, respectively. The description of exemption codes can be found on the Commandant (CG-1121), Operational Medicine Web site.
  - (2) Senior Health Services Officer (SHSO) must ensure all healthcare personnel receive appropriate training regarding the following – use of exemption codes, verifying accuracy of exemption codes of members in their clinics medical AOR, and (NON TRICARE) following up on temporary exemptions.

- d. Immunization Training. Additional immunization training opportunities are offered by the Military Vaccine Agency (MILVAX).
- e. Emergency immunizations. In some clinical situations, the medical indication may be to immunize even though the circumstances above cannot be met (e.g., tetanus toxoid for wound prophylaxis, gamma globulin for hepatitis A exposure, etc.). Such incidents commonly occur at sea and remote units or during time-sensitive situations (SAR, etc.). If the medical benefits outweigh the chance of a serious allergic reaction, take every available precaution possible, and administer the vaccine. Obtain radio, telephone, or message advice from the DMOA or Flight Surgeon on call through the closest CG command center.
- f. Adverse reaction. If an adverse reaction to a vaccine is suspected by anyone, including the vaccinee, the facility shall notify the Vaccine Adverse Event Reporting System (VAERS) using form VAERS-1. The likelihood of a causal relationship between the observed physical signs or symptoms and the vaccine does NOT need to be verified by a MO or anyone else. This reporting system is for anyone who suspects a vaccine adverse reaction. The VAERS form is obtained from the FDA on-line at <http://vaers.hhs.gov/esub/index> or by calling 1-800-822-7967. Units providing vaccinations shall maintain a supply of these forms for vaccinees who request them. Alternatively, file the VAERS online at <http://vaers.hhs.gov/esub/index>. If filing online, be sure to print a copy of the form before clicking on the “submit” button. Log the disclosure to VAERS in the Protected Health Information Management Tool (PHIMT); see Chapter 14-B of this Manual.
- g. Vaccine Information Sheet (VIS). Every health care provider who administers vaccines shall provide a Vaccine Information Sheet (VIS) if available from the CDC. A current list of the vaccines for which VIS's are available and the VIS's themselves are found at <http://www.cdc.gov/nip/publications/VIS>. The list includes vaccines covered by the National Childhood Vaccine Injury Act, as well as several others. The VIS is available via MRRS. The VIS's are also available from the CDC, National Immunization Hotline, at telephone number (800) 232-2522 or at <http://www.cdc.gov/nip/publications/VIS/default.htm>.
- h. Per the National Childhood Vaccine Injury Act (NCVIA) of 1986, health care providers are not required to obtain the signature of the vaccine recipient, parent or legal guardian acknowledging receipt of the VIS. However, to document that the VIS was given, health care providers must note in the patient's permanent medical record (1) the date printed on the VIS and (2) the date the VIS is given to the patient or legal guardian. In addition, the NCVIA requires, for all vaccines, that health care providers document in the patient's permanent medical record the following: (1) date the vaccine was given, (2) the vaccine manufacturer and lot number and (3) the name and address of the health care provider administering the vaccine. For all beneficiaries, the health care provider shall make a notation on the Chronological Record of Care, Form SF-600 stating that the vaccine recipient or

legal guardian/representative has been given information on the vaccine(s) prior to the vaccine(s) being given, if applicable. For all vaccines, facilities administering vaccines must record the manufacturer and lot number of the vaccine, and the name, address and title of the person administering the vaccine in the recipient's health record and if requested in the service member's International Certificate of Vaccination, Form CDC-731.

5. Immunization on Reporting for Active Duty for Training.

- a. When a member reports for active duty training, the receiving unit shall review the individual's immunization information in MRRS, administer any delinquent immunizations whenever possible, and enter the information in MRRS and reprint out the Adult Preventative and Chronic Care Flowsheet, Form DD-2766.
- b. The individual's Reserve unit shall give the member a re-immunization schedule for the following year if one is needed for that period.

6. Specific Vaccination Information.

- a. CG policy. CG policy concerning immunizations follows the recommendations of the CDC and ACIP, unless there is a military relevant reason to do otherwise. Any immunizing agent licensed by the FDA or DHHS may be used. Privileged health care providers may make clinical decisions for individual beneficiaries to customize medical care to respond to an individual clinical situation.
- b. Detailed information. Detailed information on adult vaccines can be found in the Immunizations and Chemoprophylaxis, COMDTINST M6230.4 (series). Accessions include recruits, cadets, band members and Direct Commissioned Officer participants.
- c. Adenovirus. Administer adenovirus vaccine to CG recruits IAW Immunizations and Chemoprophylaxis, COMDTINST M6230.4 (series).
- d. Anthrax. Administer anthrax vaccine in accordance with the Coast Guard Anthrax Vaccine Immunization Program (AVIP), review COMDTINST M6230.3 (series). The anthrax vaccine is now given via the intramuscular route and the dosing schedule is now 5 doses.
- e. Hepatitis A. Administer Hepatitis A to all AD and SELRES CG personnel (including accessions). Immunization may be accomplished with single-antigen Hepatitis A vaccine or combined Hepatitis A-Hepatitis B vaccine (Twinrix). Ensure the accurate dosing schedule is followed for single antigen Hepatitis A and/or Twinrix. The dosing schedule can be found on the Commandant (CG-1121) Operational Medicine website. The single-antigen Hepatitis A dosing schedule is 0 and 6 months. Single-antigen Hepatitis A is indicated for individuals 19 years and older. Ensure the pediatric dose of Hepatitis A is given for individuals who are less

than 19 years old. CG personnel who are less than 18 years of age cannot receive Twinrix. Performance of serology testing for accessions is recommended prior to administering the vaccine.

- f. Hepatitis B. Administer Hepatitis B to all AD and SELRES CG personnel (including accessions). Immunization may be accomplished with single-antigen Hepatitis B vaccine or combined Hepatitis A-Hepatitis B vaccine (Twinrix). Ensure the accurate dosing schedule is followed for single antigen Hepatitis B and/or Twinrix. The dosing schedule can be found on the Commandant (CG-1121) Operational Medicine website. The single-antigen Hepatitis B dosing schedule is 0, 1 month and 6 months. Single-antigen Hepatitis B is indicated for individuals 20 years and older. Ensure the pediatric dose of Hepatitis B is given for individuals who are less than 20 years old. CG personnel who are less than 18 years of age cannot receive Twinrix. Performance of serology testing for accessions is recommended prior to administering the vaccine.
- (1) Healthcare personnel will have documentation of serological evidence of immunity against the Hepatitis B virus (HBV) or a record of completion of the 2-dose Hepatitis B (or Twinrix) vaccination series. All personnel who completed the series after 1 May 2008 will be tested for serological evidence of immunity. Those who completed the series prior to 1 May 2008 do not require serological evidence of immunity and should be tested only in the event of a potential HBV exposure.
  - (2) New healthcare personnel who cannot provide documented serological evidence of immunity against HBV or a record of completion of the three dose Hepatitis B (or Twinrix) vaccination series will begin the Hepatitis B (or Twinrix) vaccination series, unless the vaccine is medically contraindicated.
  - (3) For healthcare personnel, anti-HBs titers should be drawn 1 to 2 months after completion of the three dose Hepatitis B (or Twinrix) vaccination series. If serological testing is delayed due to operational considerations, testing must be accomplished within one year after series completion.
  - (4) Healthcare personnel who do not develop serological evidence of immunity after the initial vaccination series will complete a second 3-dose series.
  - (5) Revaccinated healthcare personnel will be tested for anti-HBs titer 1 to 2 months after the last dose of vaccine. Personnel negative after a second vaccine series are considered non-responders to the Hepatitis B (or Twinrix) vaccination (and likely still susceptible to HBV) and should be documented susceptible in MRRS.
- g. Human Papilloma Virus (HPV). The HPV vaccine is not a mandatory immunization. It is highly recommended that healthcare providers recommend use of the HPV vaccine in accordance with ACIP guidelines.
- h. Influenza A and B. Administer the influenza vaccine annually to all AD and SELRES CG personnel (including accessions) and CG civilian personnel as

delineated in Civilian Employee Health Care and Occupational Health Program, COMDTINST 12792.3 (series)

- i. Japanese encephalitis. Administer JEV to AD and SELRES CG personnel who will be stationed at least 30 days in rural areas of Asia where there is substantial risk of exposure to the virus, especially during prolonged field operations at night. Administer booster doses according to the manufacturer's recommendations if risk of exposure is still present. Under normal circumstances, personnel cannot embark on international travel within ten days of JEV immunization because of the possibility of delayed allergic reactions.
- j. Measles, Mumps, and Rubella. Administer MMR vaccine to all AD and SELRES CG personnel born after 1957 (including accessions). Ensure they have received two lifetime doses of MMR vaccine or have positive serologic test results. Unless there is reason to suspect otherwise (e.g. childhood spent in a developing country, childhood immunizations not administered), a childhood dose of MMR vaccine may be assumed. Proof of immunity via serology testing or prior history of completed vaccination series (per medical documentation) will be accepted. Document immunization or results of proof of immunity in MRRS. For personnel whose records show receipt of bivalent measles-rubella vaccine, administration of MMR vaccine to achieve immunity against mumps is not necessary as a military requirement, but may be appropriate in exceptional clinical circumstances.
- k. Meningococcal disease. Administer meningococcal vaccine (Menactra) to all accessions. Proof of vaccination with Menactra within one year of accession will be accepted. The need for, and timing of, a booster dose of Menactra will be determined in the coming years. Administer Menactra to personnel traveling for 15 or more days to regions subject to meningococcal outbreaks.
- l. Pneumococcal disease. Administer pneumococcal vaccines per ACIP guidelines.
- m. Poliomyelitis. Administer a single booster dose of IPV to all CG accessions (IPV administration can be done within one year of arrival to the accession point). Personnel who have not received primary series must complete the series using IPV. Unless there is reason to suspect otherwise (for example, childhood in a developing country, childhood immunizations not administered), receipt of the basic immunizing series of IPV may be assumed.
- n. Rabies. Administer rabies vaccines per ACIP guidelines.
- o. Smallpox. Administer the smallpox vaccine in accordance with the Coast Guard Smallpox Vaccine Program (SVP), COMDTINST M6230.10 (series). For smallpox VAER events, CG healthcare personnel must continue to use the VAERS and must also report smallpox vaccine (ACAM 2000) cardiac-related adverse events to the

Naval Health Research Center (NHRC) at 619-553-9255. Upon receipt of the report, NHRC personnel will contact eligible cases and request their consent to participate in the Smallpox Vaccine Myopericarditis Registry.

- p. Tetanus, Diphtheria, and Pertussis. Administer booster doses of Td or Tdap to all AD and SELRES every ten years. Adults 19 to 64 years old should substitute Tdap for one booster dose of Td. Td should be used for later booster doses. Tdap is not to be confused with Dtap which is administered in the pre-school age group (six years of age and younger).
  - q. Typhoid fever. Administer typhoid vaccine to all AD and SELRES before overseas deployment to typhoid-endemic areas.
  - r. Varicella. Administer varicella vaccine to all accessions who do not have medical documentation (proof of disease, prior immunization, serology). Serologic screening is the preferred means of determining those susceptible to varicella infection. Do not use a questionnaire.
  - s. Yellow fever. Administer yellow fever vaccine to all accessions. Boosters will be administered as per the Immunizations and Chemoprophylaxis, COMDTINST M6230.4 (series).
7. Allergy Immunotherapy (AIT).
- a. AIT shall not be performed by IDHS in sickbays. AIT shall be restricted to clinics or sickbays only when Medical Officers (with current ACLS certification) are present in the clinic.
  - b. AIT can only be performed by trained providers including HS, IDHS, nurses and Medical Officers who have completed one of three approved training courses:
    - (1) United States Air Force's Introduction to Allergy/Allergy Extender Program.
    - (2) United States Army's Walter Reed Immunization Technicians' Course.
    - (3) United States Navy's Remote Site Allergen Immunotherapy Administration Course. For the Navy's remote course, the Medical Officer must provide face-to-face training to the HS/IDHS. This course will be available on CG Central in the Commandant (CG-1121) Allergy Immunotherapy Administration Microsite.
  - c. All personnel involved in the administration of allergen immunotherapy will participate in annual refresher training.
  - d. All HSs, nurses and Medical Officers must have completed the training and be designated in writing to administer AIT by the SMO/DSMO/SHSO. After receiving appropriate training, HSs, nurses and Medical Officers are only authorized to give AIT to AD and SELRES members and only at maintenance

doses. Clinical personnel should not initiate immunotherapy or give escalating doses.