APPLICATION FOR APPROVAL OF LOCAL VACCINATION PROGRAMME

Name of Programme (e.g. clinic name) .....

Full Name of Applicant responsible for programme .....

Expiry date of current approval (if applicable) .....

Address (Work) .....

Phone (Work) .....

Email .....

1. VACCINE(S) TO BE DELIVERED (TRAVEL VACCINES ARE NOT PERMITTED)	
2. LOCATION	
Specify location(s) – may be more than one (e.g. workplace, home, clinic)	
3. STAFF	**Please circle**
Will there be 2 people present during the immunisation event - **one of whom will be an authorised independent vaccinator; the other will be either a registered nurse or have basic life support training**?	Y / N
4. LINKAGES	**Please circle**
Do you have processes for regular contact with your local immunisation facilitator?	Y / N
5. NAME(S) OF AUTHORISED VACCINATORS PARTICIPATING IN PROGRAMME, & CURRENT AUTHORISATION EXPIRY DATE(S)	
6. LEGAL	**Please circle**
Do you have knowledge of the following Legislation? ○ The Code of Health and Disability Consumers' Rights Regulation 1996 ○ Privacy Act 1993 (Storage and Transfer of Information) ○ The Health and Safety at Work Act 2015 (Having a suitable post vaccination observation area, correct disposal of vaccines/needles, etc) ○ Medicines Act 1981 (See p 615-627, Appendix 3, Section A3.6 in the Immunisation Handbook 2017)	 Y / N Y / N Y / N Y / N
7. VENUE	**Please circle**
Does the venue allow for safe management of delivery of immunisations by providing: ○ Privacy? ○ Resting/waiting space? ○ Maintenance of privacy of records?	 Y / N Y / N Y / N
8. VACCINE RECOMMENDATIONS, ELIGIBILITY AND DOCUMENTATION	**Please circle**
Have you documented processes for the following? * • Pre-vaccination information including consent • Identification of people eligible for free vaccination • Cold Chain management **	 Y / N Y / N Y / N
8. VACCINE RECOMMENDATIONS, ELIGIBILITY & DOCUMENTATION continued	**Please circle**

• Recording patient details, vaccine administration, and any adverse events following immunisation (AEFI) • Notification to Primary Care Provider of vaccines given • Post-vaccination information (including provision of emergency care) • Reporting of adverse reactions For influenza vaccinations: It will be necessary to provide the following information to the Medical Officer of Health: o Number of recipients who were >65 yrs (all eligible for free vaccine) o Number of recipients < 65 years who are eligible for free vaccine o Number of non-eligible influenza vaccines given	Y / N Y / N Y / N Y / N

9. EQUIPMENT	Please Tick **Y**	**N**
Do you have the following available?		
• Cell phone/phone access		
• Oxygen cylinder, flow meter, tubing, paediatric and adult masks		
• Airways - from paediatric to large adult		
• Ambu bag – infant/adult		
• Adrenaline		
• Syringes 1ml 3ml 5ml Needles 5/8" 1" 1½ (1.58cm to 3.8cm)		
• Sharps box		
• Alcohol swabs, cotton wool swabs/gauze/plasters		
• Thermometer/sphygmomanometer/stethoscope		
• Vaccines		
• Appropriately monitored vaccine storage*		
• Min/Max thermometer or recording device for monitoring		
• Gloves		
• 0.5% Hypochlorite		
• Approved biohazard bag		
10. OPTIONAL ADDITIONAL EMERGENCY EQUIPMENT	**Y**	**N**
• Intravenous cannula & administration sets		
• Intravenous fluids		
• Hydrocortisone for injection		
• Antihistamine for injection		
• Sodium Bicarbonate		
• Saline flush		

* Documentation will be subject to periodic audit ** See the IMAC Cold Chain Standards

SIGNATURE: ……

DATE: ……

Please return to:

Public Health Service / PO BOX 647 / Nelson 7040
Fax: 03-546 1542 or via email to gayle.lawrie@nmdhb.govt.nz