Vaccination of Adults: Performing

What is Involved in Performing Vaccination of Adults?
› Vaccination is the process of introducing a vaccine (i.e., a product containing antigens to a disease that stimulates the body to develop antibodies) into the body to promote immunity to the targeted disease (i.e., become immunized) without developing the disease. The vaccine can be an inactivated virus or bacterium (e.g., tetanus toxoid) or a live attenuated virus (e.g., the measles vaccine) or bacterium. This Nursing Practice & Skill paper will discuss performing vaccination in adults (for information on performing vaccination in children, see Nursing Practice & Skill ... Vaccination of Children: Performing).

• What and How: Performing vaccination of adults is a moderately invasive procedure that involves the introduction of an inactivated or live attenuated virus or bacterium into the body as a transdermal, subcutaneous, or intramuscular (I.M.) injection or via the oral or intranasal route.

• Where: Vaccination is typically performed in an outpatient healthcare setting (e.g., clinic, physician’s office), but can be performed at a pharmacy (e.g., influenza vaccine), in the nursing office of a school, a community health setting, or an inpatient setting.

• Who: Vaccination can be performed by nurses, physicians, and other appropriately trained healthcare professionals. This procedure should not be delegated to assistive staff members (e.g., nurses’ aides). With the patient’s consent, it is appropriate for family members to be present during vaccination.

What is the Desired Outcome of Vaccination of Adults?
› Vaccination promotes immunization against certain communicable, potentially severe/ life-threatening, or chronically disabling infectious diseases, and is performed throughout the lifespan to reduce risk for morbidity and mortality due to vaccine-preventable infectious diseases.

Why is Performing Vaccination of Adults Important?
› After vaccination, the body develops antibodies that promote a swift immunologic response to the virus or bacterium if it is reencountered. This response can prevent or diminish the severity of the disease and reduce risk for mortality.

• Vaccination reduces overall health care costs and improves workforce productivity and school attendance by decreasing the number of days lost as a result of vaccine-preventable illness.

• Although many infectious diseases have been eradicated in the United States, vaccination to protect against these diseases is important because they could be prevalent—or even endemic—in other parts of the world. Travelers who become infected can bring the infection to the U.S. and children can be unknowingly exposed.

Facts and Figures
› During the 2018–2019 influenza season, 45.3% of American adults who were 18 years of age and older received the influenza vaccine; vaccination rates were much higher in persons who were 50–64 years of age (47.3%) and those who were greater than 65 years of age (68.1%) than in persons who were 18–49 years of age (34.9%) (CDC, 2019).

• Pregnant women are at increased risk for developing severe influenza. Among women who were pregnant during the 2016–2017 influenza season, an estimated 62.8%
received the influenza vaccination either before or during pregnancy; the majority of pregnant women who elected to receive influenza vaccination received a clinician recommendation (CDC, 2019; King, Hanson, Donahue et al, 2020)

- Although asthma is not a risk factor for developing influenza, persons with asthma are at increased risk for developing severe asthma. Influenza in patients with asthma can trigger asthma attacks and lead to pneumonia and other severe complications. During the 2015–2016 influenza season, just 46.7% of persons with asthma received the influenza vaccine (CDC, 2018)

- Influenza vaccination effectiveness declines with age due to age-related immune system deterioration that results in an ineffective response to vaccination. Influenza vaccination effectiveness is significantly higher among adults 19-64 years of age (51%) compared to those 65 years of age and older (37%). (Rondy, Omeiri, Thompson, Leveque, Moren, & Sullivan, 2017)

- As of the 2019-20 Influenza Season, annual influenza vaccination is recommended for everyone over 6 months of age with any licensed influenza vaccine, with no preference given for any one vaccine over another. Both inactivated and live attenuated influenza vaccines are currently being recommended

What You Need to Know Before Performing Vaccination of Adults

- The terms “vaccination” and “immunization” should not be used interchangeably
  - Vaccination refers to the administration of a virus or bacterium that has been killed (i.e., inactivated) or weakened (i.e., live attenuated) to stimulate the immune system to develop antibodies to the organism
    - The closer the vaccine resembles the disease-causing virus or bacterium, the stronger the immune response will be
  - Immunization refers to the process of becoming immune to a virus or bacterium (i.e., the organism is incapable of producing illness in the individual when exposed to the organism)
    - Immunity can be
      - passive (i.e., the individual receives antibodies from another individual, such as with placental transfer of antibodies); passive immunity is not life-long, and disappears slowly over weeks or months
      - active (i.e., the individual’s immune system mounts an immune response following activation by a virus or bacterium); active immunity may last a lifetime. Native infection with the disease-causing organism or vaccination both result in active immunity

- The U.S. Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) routinely updates the immunization schedule. Please refer to the most current CDC ACIP schedule to determine immunization needs. Currently, the ACIP recommends the following immunization schedule for adults who are 19 years of age and older (CDC, 2020):
  - Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination
    - All adults should receive a Td booster every 10 years. Those who have never received a dose of Tdap should receive a single dose of Tdap followed by a booster every 10 years
    - Individuals who may not have completed an original three-dose series should receive/complete the series; the second dose is administered at least 4 weeks after the first, and the third dose is administered 6-12 months after the second. Tdap can be substituted for any Td dose, but preferred as first dose.
    - Women should receive the Td/Tdap vaccine during each pregnancy regardless of the time since prior vaccination
    - The American College of Obstetricians and Gynecologists recommends that pregnant women receive the Tdap vaccine at 27–36 weeks’ gestation
    - Contraindications to the Td/Tdap vaccine
      - History of severe allergic reaction (e.g., anaphylaxis) after initial vaccination or known allergic reaction to a vaccine component
      - Encephalopathy (i.e., a condition characterized by decreased level of consciousness, coma, and prolonged seizures not attributable to another identifiable cause) can develop within 7 days of vaccine administration

  - Human papilloma virus (HPV) vaccination
    - HPV vaccination is recommended for all adults through 26 years of age. A two or three-dose series is required, depending on age at initial vaccination; age 15 years or older at initial vaccination: 3 dose series, with the second dose being administered at least 4 weeks after the first, and the third shot being administered at least 12 weeks after the second. If age 9 to 14 years of age at initial vaccination and receive 1 dose or 2 doses less than 5 months apart, only 1 additional dose needed. If age 9 to 14 years of age at initial vaccination and receive 2 doses at least 5 months apart, vaccination complete and no additional doses are needed
    - Patients aged 27 through 45 may also receive a 2 or 3 dose series of the vaccine based on shared clinical decision-making
Contraindications to the HPV vaccine
- History of severe allergic reaction (e.g., anaphylaxis) to a vaccine component
- Vaccination during pregnancy is not recommended

Varicella (i.e., chicken pox) vaccination
- Unless medically contraindicated, all adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine, 4-8 weeks apart, if not previously vaccinated, or receive a second dose if they previously received only 1 dose
- Health care personnel without evidence of immunity should also be vaccinated
- Contraindications to the varicella vaccine
  - History of severe allergic reaction (e.g., anaphylaxis) to initial vaccination or known allergy to a vaccine component
  - Substantial suppression of cellular immunity
  - Pregnancy

Herpes zoster vaccination
- A 2-dose series of zoster vaccine (Shingrix), 4 weeks apart, is recommended for adults who are ≥ 50 years of age regardless of whether or not they report having a prior episode of herpes zoster
- Contraindications to the herpes zoster vaccine
  - Known allergic reaction (e.g., anaphylaxis) to a vaccine component
  - Substantial suppression of cellular immunity
  - Pregnancy

Measles, mumps, and rubella (MMR) vaccination
- Measles component
  - Adults who were born in 1957 or later should receive 1 or 2 doses of MMR vaccine unless they have a medical contraindication, documentation of vaccination with 1 or more doses of MMR vaccine, laboratory evidence of immunity, or documentation of physician-diagnosed measles; the doses are administered at least 28 days apart
- Mumps component
  - Adults vaccinated prior to 1979 at high risk for mumps (e.g., healthcare personnel) should be vaccinated with 2 doses of MMR at least 28 days apart
- Rubella component
  - All women of childbearing age and women who have just completed or terminated a pregnancy should be vaccinated if there is no evidence of immunity (e.g., positive blood titer)
- Contraindications to the MMR vaccine
  - History of severe allergic reaction (e.g., anaphylaxis) to a previous MMR vaccine or known allergy to a vaccine component
  - Pregnancy
  - Known severe immunodeficiency (e.g., due to hematologic and solid tumors, receiving chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy, or HIV infection with severe immunocompromise)

Seasonal influenza (i.e., the flu) vaccination
- All adults should receive seasonal influenza vaccination
- Vaccination is highly recommended for everyone 6 months or older every year
- Contraindications to the seasonal influenza vaccine
  - History of severe allergic reaction (e.g., anaphylaxis) following seasonal influenza vaccination or known allergy to a vaccine component
  - Patients with egg allergies may still receive the vaccine, but it must be given under medical supervision
  - Moderate or severe acute illness with or without fever
  - Known severe immunodeficiency (e.g., due to hematologic or solid tumors, receiving chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy, or HIV infection with severe immunocompromise)
  - History of GBS within 6 weeks of a previous dose of influenza vaccine, unless benefits outweigh the risks
- Live attenuated influenza vaccine should not be given to pregnant women. Inactivated influenza vaccine should be used during pregnancy.
- Live attenuated vaccine should not be given to patients with a history of severe allergic reactions, asplenia, cochlear implants, cerebrospinal fluid-oro-pharyngeal communication, patients with immunocompromised conditions or their caregivers/close contacts, or patients who received antiviral medication within the previous 48 hours
• Hepatitis A vaccination
  – The hepatitis A vaccine should be given to all adults who request it as well as to MSM, illicit drug users, persons who have been occupationally exposed to hepatitis A virus (HAV), persons with chronic liver disease or who are receiving clotting factor concentrates, HIV infection, persons who travel to or work in countries where HAV is endemic, and unvaccinated adults who have close personal contact with an international adoptee
  – Contraindications to the hepatitis A vaccine
    - History of severe allergic reaction (e.g., anaphylaxis) to a previous hepatitis A vaccination or known allergy to a vaccine component
  – Both 2 and 3-dose vaccines are available. A 2-dose series of Hepatitis A vaccine should be given with second dose given at least 6 months after the first dose. Or a 3-dose series given at 0, 1, and 6 months is available.

• Hepatitis B vaccination
  – Indications for the hepatitis B vaccine include being sexually active outside of a long-term mutually monogamous relationship, seeking treatment or evaluation for a sexually transmitted disease, current or recent injectable drug use, MSM, healthcare or public safety workers at risk for exposure to blood and other body fluids, diabetes mellitus (at the clinician’s discretion in patients who are ≥ 60 years of age), end-stage renal disease, HIV infection, chronic liver disease, household or sexual contact with hepatitis B surface antigen-positive persons, residence or employment in homes for developmentally disabled persons, incarcerated individuals, and international travelers to countries with high or intermediate hepatitis B prevalence
  – Contraindications to the hepatitis B vaccine
    - History of severe allergic reaction (e.g., anaphylaxis) to vaccination or known allergy to a vaccine component
    - Encephalopathy (i.e., a condition characterized by decreased level of consciousness, coma, and prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous vaccination
  – Both 2 and 3-dose vaccines are available. A 2-dose series of Hepatitis B vaccine should be given with second dose given at least 6 months after the first dose. Or a 3-dose series given at 0, 1, and 6 months is available.

• Pneumococcal vaccination
  – Currently, 2 types of pneumococcal vaccinations are available: a 23-valent polysaccharide vaccine (PPSV23) and a 13-valent pneumococcal conjugate vaccine (PCV13)
  – Adults ≥ age 65 should receive 1 dose of PPSV23. If they received a dose before age 65, a booster dose is required 5 years after the initial dose
  – Adults 65 years and older may also receive PCV13 depending on if they have previously received a pneumococcal vaccination in the past and after shared clinical decision-making discussion.
  – One or two doses of PCV13 is recommended for individuals ≥ 19 years of age if they have cochlear implant, cerebrospinal fluid leak, or are immunocompromised (see specific underlying medical condition below).
    - Underlying medical conditions include:
      - Functional or anatomic asplenia
      - Congenital or acquired immunodeficiency
      - HIV infection
      - Chronic renal, liver, lung, or heart disease
      - Alcoholism
      - Diabetes mellitus (DM)
      - Smokers
      - Nephrotic syndrome
      - Leukemia, lymphoma, generalized malignancy, or multiple myeloma
      - Solid organ transplantation
      - Cerebral spinal fluid leaks
      - Cochlear implants
      - Iatrogenic immunosuppression (e.g., radiation therapy, long-term corticosteroid use)
    - Pneumococcal vaccine should be administered at least 2 weeks prior to planned immunosuppressive therapy or splenectomy

• Meningococcal vaccination
  – Meningococcal vaccine should be administered to adults who have the following indications:
    - Medical conditions of anatomic or functional asplenia or persistent complement component deficiencies
    - First-year college students living in dormitories
- Microbiologists who are routinely exposed to isolates of *Neisseria meningitides*
- Military soldiers living in group quarters
- Persons who travel to or live in countries (e.g., sub-Saharan Africa in December through June) where meningococcal disease is hyperendemic or epidemic, especially individuals who have prolonged contact with local persons
- Travelers to Mecca during the annual Hajj

– There are two types of meningococcal vaccinations; Meningococcal serogroups A, C, W, Y vaccine (MenACWY) and meningococcal serogroup B vaccine (MenB-4C or MenB-FHbp). Refer to current CDC ACIP guidelines for recommended vaccination and dose based on age, underlying medical condition, and after shared clinical decision-making discussion.

– Contraindications to the meningococcal vaccine
  - History of severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or allergy to a vaccine component
  - History of GBS

**• Haemophilus influenzae type b (Hib) vaccination**

– One dose of Hib vaccine should be administered to patients with functional or anatomic asplenia or sickle cell disease, and to patients who will be undergoing elective splenectomy. Vaccination should be administered at least 14 days prior to splenectomy. Recipients of successful hematopoietic stem cell transplantation should receive a 3-dose series of Hib vaccine 6–12 months after transplantation; each dose is administered at least 4 weeks apart

– Contraindications to the Hib vaccine
  - History of severe allergic reaction (e.g., anaphylaxis) to previous vaccination or allergy to a vaccine component

**• COVID-19 Vaccination**

– COVID-19 vaccinations are subject to change based on availability and local conditions, please refer to your facility and state/local policies for guidance on administration. Under an emergency use authorization:
  - Persons aged 18 years and over, may receive Moderna COVID-19 vaccination, administered as 2 doses, 4 weeks apart
  - Persons aged 16 and older, under an emergency use authorization, may receive Pfizer-BioNTech COVID-19 vaccine, administered as 2 doses, 3 weeks apart
  - ACOG recommends that COVID-19 vaccines should not be withheld from pregnant or lactating persons who meet criteria for administration, although inadequate safety data exists specific to pregnant or lactating persons

› Knowledge of proper immunization technique is important

• Most immunizations are delivered I.M. because muscle tissue contains fewer pain receptors and has a better blood supply than subcutaneous tissue. I.M. administration causes less pain and is associated with fewer local reactions

– Administration in a larger muscle allows for easier I.M. injection and reduces the risk for unintended subcutaneous injection. The deltoid muscle is preferred for administration of vaccinations in adults *(Figure 1)*

![Figure 1](https://via.placeholder.com/150)

*Figure 1*: Use care to administer the intramuscular injection into the upper third of the deltoid. Copyright© 2014, EBSCO Information Services.

– I.M. injection is performed with the needle at a 90° angle to the skin *(Figure 2)*. It is important to select a needle of an appropriate length to deposit the medication deep in the muscle mass rather than subcutaneously, and to avoid over-penetrating to the periosteum because doing so causes significant pain
When administering an intramuscular injection, the syringe is held like a dart and injected into the skin at a 90 degree angle.

- Appropriate needle length for I.M. injection in adult men and women is 1-1 1/2 inch and gauge 22–25
  - Longer needle length may be required for patients who are obese
- The Z-track method for I.M. injection may be used to reduce the risk that the medication will leak upward to the subcutaneous tissues and skin, potentially causing pain and a local reaction (for more information, see Nursing Practice & Skill ... Administration of Medications: Z-track Injection)

Intranasal vaccination with live attenuated influenza vaccine (LAIV) is performed to provide a local immunologic response to influenza at the site of virus entry into the body (see Facts & Figures, above)

- Intranasal vaccines are administered with the patient in an upright position. The tip of the dispenser is placed just inside the patient’s nostril and the vaccine rapidly expelled into the patient’s nose; the patient can breathe normally during administration. If the patient sneezes following vaccination, repeat vaccination is not necessary
- Advantages of intranasal administration include that the procedure is needle-free, noninvasive, requires a small dose of vaccine, and can result in a systemic as well as a localized immune response. Disadvantages include that the vaccine is rapidly cleared from the body, there is inefficient uptake of vaccine, and the lack of human-compatible mucosal adjuvants

It is important to be fully informed of all potential adverse effects of immunization and associated nursing responsibilities for patient care

- The most common adverse effects after injected vaccines are not severe and include the following:
  - Redness and swelling at the injection site
  - Fever
  - Soreness at the injection site
- In rare cases, immunizations cause more severe adverse reactions, including the following:
  - Severe allergic reactions, including anaphylaxis
  - Seizures

Strategies that are identified by the CDC to significantly improve vaccination rates among adults include the following:

- Initiating standing orders for patient vaccination
- Initiating computerized vaccination reminders for each patient
- Instituting vaccination reminders on the patient’s medical record
- Making home visits
- Using mailed/telephoned reminders about vaccinations that are due
- Routinely providing patient education on vaccination
  - One barrier to vaccination of adults is the common misconception among adults that vaccinations are only for children
- Initiating and maintaining personal health records (e.g., a record of vaccinations) for each patient to keep

Knowledge and demonstrated competency in the following is essential:

- The “6” rights of medication administration (for more information, see Nursing Practice & Skill ... Medication Errors: Preventing --General Principles)
- Aseptic technique, particularly general aseptic non-touch technique (ANTT; for more information, see Nursing Practice & Skill ... Aseptic Technique and Infection Prevention: Applying Principles at the Bedside)
Preliminary steps that should be performed before administering vaccinations in adults include the following:

- Review the facility/unit protocol for administering vaccinations to adults, if one is available
- Review the treating clinician’s order for vaccination
  - Note the type and dose of vaccine ordered and route of administration
- Verify completion of facility informed consent documents, if appropriate
- Review the patient’s history/medical record
  - For information on allergies (e.g., to latex, medications, or other substances); use alternative materials, as appropriate
  - To determine if the patient has received all recommended vaccinations
  - To identify vaccinations that are due at the time of the current office visit

Gather supplies, which typically include the following:

- Nonsterile gloves; additional personal protective equipment (PPE; e.g., gown, mask, eye protection) may be needed if exposure to body fluids is anticipated
- Appropriate dose of vaccine to be administered
  - Check the expiration date on the vial to verify that it has not expired
- If the vaccine is to be administered I.M., the following are needed:
  - Alcohol swab or facility-approved antiseptic
  - Cotton ball
  - Adhesive bandage
  - 22-25 g needle (i.e., 1 to 1.5 inch, or longer if the patient is obese)
  - 3 cc syringe
- Vaccination record for the patient
- Written information, if available, to reinforce verbal education for the patient/family

**How to Perform Vaccination of Adults**

- Perform hand hygiene and don PPE as appropriate
- Identify the patient using at least two unique identifiers, according to facility protocol
- Establish privacy by closing the door to the examination room if in the outpatient setting, or by closing the door to the patient’s room and/or drawing the curtain surrounding the patient’s bed if in the inpatient setting
- Introduce yourself to the patient and family member(s), if present, and explain your clinical role; assess the patient and/or family for knowledge deficits and anxiety regarding vaccination
  - Determine if the patient/family requires special considerations regarding communication (e.g., due to illiteracy, language barriers, or deafness); make arrangements to meet these needs if they are present
    - Use professional certified medical interpreters, either in person or via phone, when language barriers exist
  - Explain the procedure for vaccination and its purpose; answer questions and provide emotional support and additional information as needed
- Follow ANTT throughout the procedure
- Verify the 6 “rights” of medication administration: the right patient, right drug, right dose, right route, right time, and right documentation (to be performed vaccine administration)
  - Understand further rights to be considered are right to refuse, right to be educated, right reason, and right response
- Assist the patient into a comfortable position that allows easy access to the area of the body where the vaccination will be administered
- Administer a vaccine using the I.M. route, as follows:
  - Prepare the vaccine for administration
    - Attach the needle to the syringe and uncap
    - Uncap the vial, clean with an alcohol wipe, invert, and draw up the vaccine, using ANTT
    - Place the syringe cap on a flat surface and recap, if desired
  - Administer the vaccine into a large muscle
    - Use an alcohol swab or facility-approved antiseptic to clean the injection site using a circular motion. Allow the site to air dry
    - Uncap the needle
    - Hold the syringe between the thumb and forefinger your dominant hand (as if holding a dart)
    - Use the nondominant hand to bunch up the muscle slightly
    - Use Z-track technique, if according to facility protocol
– Insert the needle at a 90° to the skin using a smooth, rapid motion
– Depress the plunger and inject the vaccine (it is not necessary to aspirate)
– Gently withdraw the needle and apply pressure to the injection site using a cotton ball
  - **Do not massage the skin or muscle tissue** at the site of the injection because doing so can irritate the muscle tissue and/or force some of the medication into the subcutaneous tissue
– Cover the injection site with a bandage if bleeding is noted

› Administer an intranasal vaccination as follows:
  • Position the patient upright or in a high-Fowler’s position
  • Remove the cover from the end of the syringe or delivery device
  • Place the tip of the syringe or delivery device just inside the patient’s nostril
  • Rapidly depress the plunger so that the entire dose of vaccine is administered
  • Remove the syringe
  • Instruct the patient to not wipe or blow the nose
  • Repeat with the other nostril

› Dispose of used materials in proper receptacles and perform hand hygiene

› Assess the patient following vaccination and educate about potential adverse effects, including allergic reactions (for details, see *Red Flags*, below). Provide written information, if available, to reinforce verbal education

› Update the patient’s plan of care, if appropriate, and document administration of the vaccination in the patient’s medical record, including the following information:
  • Date and time of the vaccination was administered
  • Description of the vaccination performed, including the type and dose of vaccination, route, vaccine manufacturer, vaccine lot number, and other information required by facility protocol
  • Patient’s response to administration of the vaccination, including pain/discomfort during and immediately after administration
  • Any unexpected patient events, interventions performed, whether or not the treating clinician was notified, and patient outcome
  • All patient/family member education provided, including topics presented, response to education provided, plan for follow-up education, barriers to communication, and techniques that promoted successful communication

**Other Tests, Treatments, or Procedures That May Be Necessary Before or After Performing Vaccination of Adults**

› Booster vaccinations are necessary for long-term immunity to certain diseases, including varicella, diphtheria, pertussis, and tetanus

**What to Expect After Performing Vaccination of Adults**

› The patient will have received all vaccinations recommended by the CDC for his/her age
› The patient will develop immunity to one or more vaccine-preventable illnesses. This immunity will prevent or reduce the severity of the illness if the patient is subsequently exposed
› The patient will obtain additional vaccinations as scheduled and remain up to date on the recommended vaccination schedule for his/her age
› The patient will return to his/her previous level of activity

**Red Flags**

› All patients should be observed after vaccination for adverse effects. Mild adverse effects include fever and/or soreness at the injection site, which can be treated with nonprescription pain medication
› Moderate adverse effects include seizures, persistent irritability, and fever ≥ 104°F/41°C. If any of these signs or symptoms develop, the patient should be reevaluated as soon as possible by the treating clinician and medical interventions provided as appropriate
› Severe adverse effects include *anaphylaxis*. Signs and symptoms of anaphylaxis include pruritus; rash; urticaria; swelling of the face, tongue, and eyelids; dyspnea; agitation; and/or alteration in consciousness. When the patient is immunized, he/she should receive verbal education and written information, if available, about signs and symptoms of adverse effects, including anaphylaxis
• Emphasize that anaphylaxis is a medical emergency and if signs and symptoms of anaphylaxis occur, the patient should contact emergency medical responders immediately for transport to the closest emergency department.

What Do I Need to Tell the Patient/Patient’s Family?

› Explain the purpose of vaccination to the patient/family and encourage questions.
› Despite the success of routine vaccination in avoiding severe cases of vaccine-preventable illnesses, misconceptions about vaccination (e.g., most persons who develop a disease have received vaccination against the disease; diseases for which vaccines are developed no longer exist in the U.S.) can delay vaccination, cause under-vaccination, or both. Patient/family teaching should address these common misconceptions to promote optimum adherence to the recommended immunization schedule.
› For more information about vaccination, refer patient/family to https://www.cdc.gov/vaccines/vac-gen/default.htm
› Educate about potential adverse effects of the vaccination(s) received, how each should be managed, and when/how to contact the treating clinician or seek immediate medical attention.
› The National Vaccine Injury Compensation Program (VICP) may compensate individuals injured by a VICP-covered vaccine and who file a petition. It is a no-fault alternative to the usual tort system for those found to have been injured by a vaccine.
› Provide information about the date and time of the next well-patient medical appointment and vaccinations if any are due at that time.

References