APPLICATION FOR APPROVAL OF AN IMMUNISATION PROGRAMME

Authority:

The Director-General of Health and local Medical Officers of Health may designate a specific immunisation programme as an “approved immunisation programme”. Such programmes are additional to the National Immunisation Schedule. Where this occurs, nurses who have been authorised by the Director-General or a Medical Officer of Health may administer vaccines covered by that specific programme without a prescription. Authorisation to administer the National Schedule vaccines does not automatically enable the vaccinator to administer vaccines to well populations or in circumstances not covered by the National Schedule. The decision of the local Medical Officer of Health to approve an immunisation programme will depend on the proposed programme meeting criteria to ensure patient safety.

I supply the following details of a proposal and request Medical Officer of Health approval for a local immunisation programme.

Business Name: ........................................................................................................................................

Person Responsible: .....................................................................................................................................

Address: .......................................................................................................................................................

......................................................................................................................................................................

Phone: ...........................................................................................................................................................

Email: ..............................................................................................................................................................

Details of Outreach Immunisation Protocol:

1. Outreach / Offsite Location/s (specify) ........................................................................................................

2. Vaccines to be administered (specify) ........................................................................................................

3. Do you give consent for us to provide your details to enquirers seeking vaccination services, if applicable? Yes / No

4. Staff

   There must be two people present for outreach or offsite immunisation – one of whom must be an Authorised Vaccinator, the other must be either a registered nurse or have first aid and basic life support training.

   Details of Authorised Vaccinators who will be providing services under this programme must be listed at end of application form.

5. Linkages with the Local and/or Regional Immunisation Coordinator Yes / No

   If “yes” specify ............................................................................................................................................

CDHB Ref: 23-11509
Authorised by: Clinical Director, CPH
Page 1 of 4

Issue date: 3 July 2019
### 6. Legal

Do you have knowledge of the Provisions contained in the following legislation:

- Privacy Act (storage and transfer of information) **Yes / No**
- The Code of Health and Disability Consumers Rights **Yes / No**
- The Health and Safety at Work Act 2015 (suitable area for post- vaccination observation, correct disposal of vaccines, etc) **Yes / No**
- Medicines Act 1981 **Yes / No**

### 7. Venue

Venue must allow for safe management of delivery of immunisations.

- Privacy **Yes / No**
- Resting space **Yes / No**
- Waiting space **Yes / No**
- Maintenance of privacy of records **Yes / No**

### 8. Documentation (Please include copies of all documentation listed below)

#### a. Preparation:

- Current Cold Chain Accreditation or Compliance Certificate.

#### b. Pre vaccination:

- What provision of information is provided to patients (including consent)?
- How will you identify persons eligible for free vaccination?

#### c. Post vaccination:

- How will patient details be recorded?
- What are the means of recording administration of a vaccine(s) and any post-vaccination adverse events?
- How will notice of administration be provided to the primary care provider?
- What information will be provided to the vaccinee post-vaccination (including provision of emergency care)?
- How will information on adverse reactions be reported.

**Note:** Please ensure that you have included all the listed documentation listed above.

### 9. Required Equipment

The following should be available:

- Cell phone / phone access **Yes / No**
- Oxygen cylinder, flow meter, tubing and paediatric / adult masks **Yes / No**
- Airways – infant through to adult **Yes / No**
- Ambubag **Yes / No**
- Adrenaline **Yes / No**
- Syringes (1ml, 2.5ml, 5ml), Needles (1.58cm to 3.8cm) **Yes / No**
- Sharps box **Yes / No**
- Alcohol swabs, Cotton wool balls / gauze etc **Yes / No**
- Thermometer and blood pressure monitoring equipment **Yes / No**
- Vaccines **Yes / No**
- Appropriate sized chilly bin and ice packs (refer to IMAC Cold Chain Standards) **Yes / No**
- Data logger with a probe, external display and alarm to monitor the temperature of the vaccines throughout the time they are stored in chilly bins at an offsite vaccination clinic **Yes / No**
- Gloves **Yes / No**
• 0.5% Hypochlorite | Yes / No
• Approved biohazard bag | Yes / No

10. Optional Additional Emergency Equipment

- Intravenous cannulae and administration sets | Yes / No
- Intravenous fluids | Yes / No
- Hydrocortisone for injection | Yes / No
- Antihistamine for injection | Yes / No
- Soda bicarbonate | Yes / No
- Saline Flush | Yes / No

11. Authorised vaccinators who will be providing programme

Only Authorised Vaccinators can give vaccines under an off-site programme. Please provide details of all Authorised Vaccinators who will be providing vaccination services under this programme. Please ensure that you advise this office if any of these vaccinators cease to provide services under this programme in the future.

1.

First name | Family Name

2.

First name | Family Name

3.

First name | Family Name

4.

First name | Family Name

5.

First name | Family Name

6.

First name | Family Name

NOTE: Please ensure you have included all documentation listed in Section 8.

Applicant signature: .................................................. Date: .........................

Approved: ................................................................. Date: .........................

Medical Officer of Health

Please scan in all documents and email to: vaccinator@cdhb.health.nz

Dr R Pink
Medical Officer of Health
Community and Public Health
P O Box 1475
CHRISTCHURCH 8140
PLEASE ALLOW UP TO 4 WEEKS FOR YOUR APPLICATION TO BE PROCESSED