NYC VACSCENE

The New York City Department of Health and Mental Hygiene — Fall/Winter 2005 • Volume 4, Number 2

New York City VacScene

New York City VacScene is published by the Bureau of Immunization
New York City Department of Health and Mental Hygiene

2 Lafayette Street, 19th Floor, CN21
New York, NY 10007
212-676-2259
FAX: 212-442-8091
nyc.gov/health

Michael R. Bloomberg
Mayor

Thomas R. Frieden, MD, MPH
Commissioner

Editorial Staff:

Jane R. Zucker, MD, MSc
Assistant Commissioner

Sheila L. Palevsky, MD, MPH
Medical Specialist-Provider Liaison

Written by:

Sheila L. Palevsky, MD, MPH
Medical Specialist-Provider Liaison

Get the message out:

It's not too late to vaccinate! Flu activity usually peaks in late January to March

Continue to vaccinate your patients, especially those at high risk.

RECOMMENDED ADULT IMMUNIZATION SCHEDULE–UNITED STATES, 2005–2006

The Advisory Committee on Immunization Practices (ACIP) annually reviews and releases the Recommended Adult Immunization Schedule.[1] This schedule provides an up-to-date tool for family physicians, family nurse practitioners, gynecologists, internists, and other health care practitioners to assess the vaccine needs of patients during office visits and to direct the administration of appropriate vaccines. These recommendations define the standard of immunization practices for persons 19 years of age and older, the population for which where there is a substantial burden of vaccine-preventable disease.

This schedule presents a tabular, color-coded summary of vaccines by age group (Figure 1) and by indication (Figure 2). Footnotes included are summaries of the most recent ACIP recommendations for specific vaccines.

The 2005–2006 Recommended Adult Immunization Schedule has been approved by the American Academy of Family Physicians (AAFP) and the American College of Obstetricians and Gynecologists (ACOG).

Tdap: Tetanus–Diphtheria–Acellular Pertussis Vaccine

The Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) voted to recommend that adults 19 to 64 years of age receive a single booster dose of a newly licensed adult tetanus, diphtheria and pertussis (whooping cough) vaccine (Tdap). Two Tdap vaccines were recently licensed by the Food and Drug Administration (FDA): BOOSTRIX®, manufactured by GlaxoSmithKline, was licensed on May 3, 2005 for use in adolescents 10 through 18 years of age; and ADACEL™, manufactured by sanofi pasteur, was licensed on June 10, 2005 for persons 11 through 64 years of age. Tdap replaces the currently recommended tetanus-diphtheria (Td) vaccine that is used for the adult tetanus booster.

1. Centers for Disease Control and Prevention. Recommended Adult Immunization Schedule–United States, October 2004-September 2006. *MMWR*. 2005;54:Q1-Q4.

Pertussis is a highly contagious respiratory tract infection. Although vaccination during early childhood is largely protective, immunity wanes over time and leaves adolescents and adults unprotected. The number of pertussis cases reported in the US in 2004 was the highest since 1959; of the 25,827 reported cases, 27% were among adults 19–64 years of age. The true number of cases in this age group is likely much higher, estimated at 600,000 cases every year.[1] The clinical presentation of pertussis in adults ranges from mild cough to symptoms of classic pertussis: paroxysmal cough, inspiratory whoop, post-tussive vomiting, cyanosis and apnea. Because of the prolonged duration of symptoms, pertussis is also known as "the 100-day cough". Complications may include sleep disturbances, rib fractures from severe cough, and pneumonia requiring hospitalization. Adults with pertussis can transmit the infection to other people including infants who are at highest risk of pertussis-related complications and death. By vaccinating these adult contacts, the risk of transmitting pertussis to infants is expected to decrease.

The ACIP recommends:

- Adults 19–64 years of age receive a single dose of Tdap (ADACEL) vaccine if their most recent tetanus toxoid-containing vaccine (e.g., Td) was ≥10 years earlier.
- Tdap should be given to parents, caretakers, and close contacts of infants less than 12 months of age, ideally at least one month before beginning such close contact.
- Tdap may be given at an interval shorter than 10 years since receipt of the last tetanus toxoid-containing vaccine to protect against pertussis. Data supports the safety of intervals as short as 2 years between administration of Td and Tdap.
- Tdap may be administered with other vaccines that are indicated at the same visit.

Earlier this year, the ACIP recommended that Tdap replace the Td booster for adolescents 11 and 12 years of age and that Tdap be given to adolescents 13 through 18 who missed the 11 to 12 year dose of Td. Adolescents 11 to 18 who have already been vaccinated with Td are encouraged to receive a dose of Tdap at intervals shorter than 10 years to add protection against pertussis.

See: www.cdc.gov/nip/vaccine/tdap/tdap_adult_recs.pdf

POLIOVIRUS INFECTION IN UNVACCINATED PERSONS

In October 2005, the Centers for Disease Control and Prevention reported the first identification of a vaccine-derived poliovirus (VDPV) in the United States (US) and the first occurrence of VDPV transmission in a community since oral poliovirus (OPV) vaccine was discontinued in 2001.[2]

Poliovirus type 1, an enterovirus, was identified in an unvaccinated, immunocompromised infant girl (index case) in a community whose members were largely unvaccinated for polio. The patient had no paralysis. Subsequently, poliovirus infection was documented in three other children within the same community. The source of the infection is unknown.

Genetic sequencing of the enterovirus isolate from a stool specimen identified this poliovirus as vaccine-derived. The extent of circulation of the VDPV within the affected community is under investigation. Identification of poliovirus infection in the index patient and other unvaccinated children in a community at high risk for poliovirus transmission raises concerns regarding 1) transmission to other communities with low levels of vaccination, and 2) the risk for a polio outbreak occurring in the US. Although this VDPV has not been associated with paralytic disease, based on previous experience with VDPVs, this virus is considered to have potential both for wider transmission and for causing paralytic disease.

Most poliovirus infections are asymptomatic or cause mild, febrile disease. Poliovirus infections occasionally cause aseptic meningitis; approximately 1 out of 200 infections result in paralytic poliomyelitis which is characterized by acute onset of flaccid paralysis that is typically asymmetric and associated with a prodromal fever. Poliovirus is spread through the oral-fecal route.

The last wild poliovirus outbreak in the US occurred in 1979 and was caused by a wild type 1 poliovirus. Cases of poliomyelitis occurred in unvaccinated persons in communities with low levels of vaccination. The most recent known VDPV isolate in the US was identified in 1995; the affected child was immunocompromised.

Inactivated polio virus vaccine, IPV, the polio vaccine currently used in the US, provides immunity against this vaccine derived poliovirus strain.

Physicians are asked to be vigilant for cases of acute flaccid paralysis (AFP) including poliomyelitis, Guillain-Barré Syndrome (GBS) and transverse myelitis, and to report all suspect cases. Stool samples, throat swabs, cerebrospinal fluid, and serum should be collected for viral culture and serology from these patients. Providers should contact the Surveillance Unit at 212-686-2284/88 (after hours at 212-POISONS) to report a suspect case of polio and for assistance with specimen collection, handling, and processing.

The Advisory Committee on Immunization Practices (ACIP) recommends that a full 3-dose IPV series be administered if polio immunization status is unknown or not documented. A booster dose of IPV is recommended for adults in susceptible communities, persons traveling to polio-endemic areas, and health care workers at high risk for exposure who have completed a primary series but have not received a booster dose.

See: www cdc.gov/mmwr/preview/mmwrhtml/mm5441a6.htm

FLU SEASON, 2005-2006

Each year, up to 20% of all persons in the United States (US) get influenza. Influenza is responsible for more than 200,000 hospitalizations and over 36,000 deaths each year in the US. A serious respiratory disease, influenza is not the same as the common cold. Unvaccinated people who get influenza (and up to half of all infections are asymptomatic) can easily spread flu to those who are vulnerable. Vaccination is the best way to prevent influenza.

There is more influenza vaccine available this season than in previous years. As influenza illness has historically peaked in mid-February, and cases have been seen in New York City into the spring months, it is recommended that influenza vaccine continue to be administered to those who have not yet been vaccinated. Providers who need flu vaccine should call 1-866-DOH1 for assistance with obtaining vaccine.

Influenza vaccine is recommended for:

- All persons 50 years of age and older; particularly those age 65 and over
- All children 6–23 months of age
- All persons with chronic medical conditions
- All pregnant women, at any stage of pregnancy
- All residents of nursing homes or other long term care facilities
- All health care workers
- All caregivers, household members, and contacts of those with high-risk conditions, especially those in contact with children up to 2 years of age.

Influenza vaccine is contraindicated in those with a history of a serious reaction (e.g., anaphylaxis) to egg protein, to a previous dose of influenza vaccine, or to any component of the vaccine. Minor illnesses with or without fever are not a contraindication to use of influenza vaccine.

Non-pregnant healthy persons 5–49 years of age can receive FluMist® (LAIV). LAIV is contraindicated only for those with direct, face-to-face contact with severely immunocompromised individuals who require protective isolation in special care units.

1. www.cdc.gov/nip/vaccine/tdap/tdap_adult_recs.pdf
2. Centers for Disease Control and Prevention. Poliovirus infections in four unvaccinated children –Minnesota, August-October 2005. MMWR 2005;54:1053-1055.

The use of brand names does not imply endorsement of any product by the NYC Department of Health and Mental Hygiene.

FIGURE 1: RECOMMENDED ADULT IMMUNIZATION SCHEDULE, BY VACCINE AND AGE GROUP — UNITED STATES, OCTOBER 2005–SEPTEMBER 2006

Vaccine ▼ / Age group ▶	19–49 years	50–64 years	≥65 years
Tetanus, diphtheria (Td)[1*]	1-dose booster every 10 yrs		
Measles, mumps, rubella (MMR)[2*]	1or 2 doses	1 dose	
Varicella[3*]	2 doses (0, 4–8 wks)	2 doses (0, 4–8 wks)	
Influenza[4*]	1 dose annually	1 dose annually	
Pneumococcal (polysaccharide)[5,6]	1–2 doses		1 dose
Hepatitis A[7*]	2 doses (0, 6–12 mos, or 0, 6–18 mos)		
Hepatitis B[8*]	3 doses (0, 1–2, 4–6 mos)		
Meningococcal[9]	1 or more doses		

These recommendations must be read along with the footnotes below.
*Covered by the Vaccine Injury Compensation Program.

Vaccines in this area are for selected populations

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., based on medical, occupational, lifestyle, or other indications)

NOTE: Tdap has been licensed for persons 19-64 years of age. Please see page 1 for details.

1. Tetanus and Diphtheria (Td) vaccination. Adults with uncertain histories of a complete primary vaccination series with diphtheria and tetanus toxoid-containing vaccines should receive a primary series using combined Td toxoid. A primary series for adults is 3 doses; administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. Administer 1 dose if the person received the primary series and if the last vaccination was received ≥10 years previously. Consult the ACIP statement for recommendations for administering Td as prophylaxis in wound management (www.cdc.gov/mmwr/preview/mmwrhtml/00041645.htm). The American College of Physicians Task Force on Adult Immunization supports a second option for Td use in adults: a single Td booster at age 50 years for persons who have completed the full pediatric series, including the teenage/young adult booster. A newly licensed tetanus-diphtheria-acellular pertussis vaccine, Tdap, is available for adults 19-64 years of age. ACIP recommendations for its use are outlined on page 1.

2. Measles, Mumps, Rubella (MMR) vaccination. *Measles component:* adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive ≥1 dose of MMR unless they have a medical contraindication, documentation of ≥1 dose, history of measles based on health care provider diagnosis, or laboratory evidence of immunity. A second dose of MMR is recommended for adults who 1) were recently exposed to measles or in an outbreak setting; 2) were previously vaccinated with killed measles vaccine; 3) were vaccinated with an unknown type of measles vaccine during 1963–1967; 4) are students in postsecondary educational institutions; 5) work in a health care facility; or 6) plan to travel internationally. Withhold MMR or other measles-containing vaccines from HIV-infected persons with severe immunosuppression. *Mumps component:* 1 dose of MMR vaccine should be adequate for protection for those born during or after 1957 who lack a history of mumps based on health care provider diagnosis or who lack laboratory evidence of immunity. *Rubella component:* administer 1 dose of MMR vaccine to women whose rubella vaccination history is unreliable or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, routinely determine rubella immunity and counsel women regarding congenital rubella syndrome. Do not vaccinate women who are pregnant or might become pregnant within 4 weeks of receiving the vaccine. Women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health care facility.

3. Varicella vaccination. Varicella vaccination is recommended for all adults without evidence of immunity to varicella. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (health care workers and family contacts of immunocompromised persons) or 2) are at high risk for exposure or transmission (e.g., teachers of young children; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers). Evidence of immunity to varicella in adults includes any of the following: 1) documented age-appropriate varicella vaccination (i.e., receipt of 1 dose before age 13 years or receipt of 2 doses [administered at least 4 weeks apart] after age 13 years); 2) born in the United States before 1966; 3) history of varicella disease based on health care provider diagnosis, parental or self-report of typical varicella disease for non-U.S.-born persons born before 1966 and all persons born during 1966–1997 (for a patient reporting a history of an atypical, mild case, health care providers should seek either an epidemiologic link with a typical varicella case or evidence of laboratory confirmation, if it was performed at the time of acute disease); 4) history of herpes zoster based on health care provider diagnosis; or 5) laboratory evidence of immunity. Do not vaccinate women who are pregnant or might become pregnant within 4 weeks of receiving the vaccine. Assess pregnant women for evidence of varicella immunity. Women who do not have evidence of immunity should receive dose 1 of varicella vaccine upon completion or termination of pregnancy and before discharge from the health care facility. Dose 2 should be given 4–8 weeks after dose 1.

continued on page 5

FIGURE 2: RECOMMENDED ADULT IMMUNIZATION SCHEDULE, BY VACCINE AND MEDICAL AND OTHER INDICATIONS — UNITED STATES, OCTOBER 2005–SEPTEMBER 2006

Indication ▶ / Vaccine ▼	Pregnancy	Congenital immunodeficiency; leukemia; lymphoma; generalized malignancy; cerebrospinal fluid leaks; therapy with alkylating agents, antimetabolites, radiation, or high-dose corticosteroids	Diabetes; heart disease; chronic pulmonary disease; chronic liver disease, including chronic alcoholism	Asplenia[10] (including elective splenectomy and terminal complement component deficiencies)	Kidney failure, end-stage renal disease, recipients of hemodialysis or clotting factor concentrates	Human immunodeficiency virus (HIV) infection[2,10]	Health care workers
Tetanus, diphtheria (Td)[1]*	1-dose booster every 10 yrs						
Measles, mumps, rubella (MMR)[2]*			1 or 2 doses				
Varicella[3]*			2 doses (0, 4–8 wks)				2 doses
Influenza[4]*	1 dose annually			1 dose annually	1 dose annually		
Pneumococcal (polysaccharide)[5,6]	1–2 doses	1–2 doses					1–2 doses
Hepatitis A[7]*	2 doses (0, 6–12 mos, or 0, 6–18 mos)						
Hepatitis B[8]*	3 doses (0, 1–2, 4–6 mos)				3 doses (0, 1–2, 4–6 mos)		
Meningococcal[9]	1 dose			1 dose	1 dose		

These recommendations must be read along with the footnotes below.

*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., based on medical, occupational, lifestyle, or other indications)

Contraindicated

NOTE: Tdap has been licensed for persons 19-64 years of age. Please see page 1 for details.

This schedule indicates the recommended age groups and medical indications for routine administration of currently licensed vaccines for persons aged ≥19 years. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations, consult the manufacturers' package inserts and the complete statements from the ACIP (www.cdc.gov/nip/publications/acip-list.htm).

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available by telephone, 800-822-7967, or from the VAERS website at www.vaers.hhs.gov.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/osp/vicp or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington D.C. 20005, telephone 202-357-6400.

For additional information about the vaccines, vaccine supply, and contraindications for immunization, please visit www.cdc.gov/nip or www.nyc.gov/health or call the New York City Department of Health and Mental Hygiene Bureau of Immunization at 212-676-2259.

Approved by the Advisory Committee on Immunization Practices (ACIP), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP).

Effective August 18, 2005, the New York City Health Code was amended to allow the Citywide Immunization Registry (CIR) to accept reports of immunizations given to all persons 19 years and older with the individual's consent for such reporting documented in their medical record. For information about the CIR and reporting call 212-676-2323.

SAVE THE DATES:

Epidemiology & Prevention of Vaccine-Preventable Diseases
February 9, 16, 23, and March 2, 2006
Satellite Broadcast & Webcast
For more information or to register go to www.ppho.cdc.gov.PHTN/epv06
Webcasts are archived at www.cdc.gov/nip/ed/video_selfstudy.htm

4. Influenza vaccination. *Medical indications:* chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or HIV); any condition (e.g., cognitive dysfunction, spinal cord injury, seizure disorder or other neuromuscular disorder) that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration; and pregnancy during the influenza season. No data exist on the risk for severe or complicated influenza disease among persons with asplenia; however, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia. *Occupational indications:* health care workers and employees of long-term care and assisted living facilities. *Other indications:* residents of nursing homes and other long-term care and assisted living facilities; persons likely to transmit influenza to persons at high risk (i.e., in-home household contacts and caregivers of children birth through 23 months of age, or persons of all ages with high-risk conditions); and anyone who wishes to be vaccinated. For healthy nonpregnant persons aged 5–49 years without high-risk conditions who are not contacts of severely immunocompromised persons in special care units, intranasally administered influenza vaccine (FluMist®) may be administered in lieu of inactivated vaccine.

5. Pneumococcal polysaccharide vaccination. *Medical indications:* chronic disorders of the pulmonary system (excluding asthma); cardiovascular diseases; diabetes mellitus; chronic liver diseases, including liver disease as a result of alcohol abuse (e.g., cirrhosis); chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection [vaccinate as close to diagnosis as possible when CD4 cell counts are highest], leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, organ or bone marrow transplantation); chemotherapy with alkylating agents, antimetabolites, long-term corticosteroids; and cochlear implants. *Other indications:* Alaska Natives and certain American Indian populations; residents of nursing homes and other long-term care facilities.

6. Revaccination with pneumococcal polysaccharide vaccine. One-time revaccination after 5 years for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, organ or bone marrow transplantation); or chemotherapy with alkylating agents, antimetabolites, or high-dose, long-term corticosteroids. For persons aged ≥65 years, one-time revaccination if they were vaccinated ≥5 years previously and were aged <65 years at the time of primary vaccination.

7. Hepatitis A vaccination. *Medical indications:* persons with clotting factor disorders or chronic liver disease. *Behavioral indications:* men who have sex with men or users of illegal drugs. *Occupational indications:* persons working with hepatitis A virus (HAV)-infected primates or with HAV in a research laboratory setting. *Other indications:* persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (for list of countries, visit www.cdc.gov/travel/diseases.htm#hepa) as well as any person wishing to obtain immunity. Current vaccines should be given in a 2-dose series at either 0 and 6–12 months (HAVRIX®) or 0 and 6–18 months (VAQTA®). If the combined hepatitis A and hepatitis B vaccine is used, administer 3 doses at 0, 1, and 6 months.

8. Hepatitis B vaccination. *Medical indications:* hemodialysis patients (use special formulation [40 µg/mL] or two 20-µg/mL doses) or patients who receive clotting factor concentrates. *Occupational indications:* health care workers and public safety workers who have exposure to blood in the workplace; and persons in training in schools of medicine, dentistry, nursing, laboratory technology, and other allied health professions. *Behavioral indications:* injection-drug users; persons with more than one sex partner in the previous 6 months; persons with a recently acquired sexually transmitted disease (STD); and men who have sex with men. *Other indications:* household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infection; clients and staff of institutions for the developmentally disabled; all clients of STD clinics; inmates of correctional facilities; or international travelers who will be in countries with high or intermediate prevalence of chronic HBV infection for >6 months (for list of countries, visit www.cdc.gov/travel/diseases.htm#hepa).

9. Meningococcal vaccination. *Medical indications:* adults with anatomic or functional asplenia, or terminal complement component deficiencies. *Other indications:* first-year college students living in dormitories; microbiologists who are routinely exposed to isolates of *Neisseria meningitidis*; military recruits; and persons who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the "meningitis belt" of sub-Saharan Africa during the dry season [Dec–June]), particularly if contact with the local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj. Meningococcal conjugate vaccine (MCV4) is preferred for adults meeting any of the above indications who are aged ≤55 years, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative. Revaccination after 5 years may be indicated for adults previously vaccinated with MPSV4 who remain at high risk for infection (e.g., persons residing in areas in which disease is epidemic).

10. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used. *Haemophilus influenzae* type b conjugate vaccines are licensed for children aged 6 weeks–71 months. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults with the chronic conditions associated with an increased risk for Hib disease. However, studies suggest good immunogenicity in patients who have sickle cell disease, leukemia, or HIV infection or who have had splenectomies; administering vaccine to these patients is not contraindicated.

The use of brand names does not imply endorsement of any product by the NYC Department of Health and Mental Hygiene.

Vaccine Adverse Event Reporting System (VAERS)

Report all clinically significant post-vaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). VAERS is a national vaccine safety surveillance program established in 1990 under the joint administration of the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) to accept reports of suspected adverse events after administration of any vaccine licensed in the United States. VAERS collects, investigates and analyzes information from reports of adverse events following immunization. By monitoring reports of adverse events which may range from mild to severe, VAERS helps to identify important new safety concerns and assists in ensuring that the benefits of vaccines continues to far outweigh any risks.

Anyone can report to VAERS. Many different types of events occur after vaccination; these may or may not have been caused by an immunization. Any significant reaction following vaccination should be reported to VAERS regardless of whether or not one can be certain the vaccine caused the reaction. Reports of adverse events can be voluntarily submitted by health care providers, vaccine manufacturers, vaccine recipients or their parents/guardians at www.vaers.hhs.org or 800-822-7967.

NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE BUREAU OF IMMUNIZATION

Citywide Immunization Registry (CIR) 212-676-2323
or www.nyc.gov/health/cir

Vaccines for Children Program (VFC).....212-447-8175

Immunization Disease (Case) Reporting 212-676-2284/88
after hours.....212-POISONS

Vaccine Adverse Event Reporting 212-676-2284/88
or 1-800-822-7967
or www.vaers.hhs.org

Immunization Medical Consultation 212-676-2259

Perinatal Hepatitis B Program 718-520-8245

Adult Immunization Initiatives 212-676-2283

Public Health Education and Training 212-368-9600

Bureau of Immunization Hotline.....212-676-2273

Bureau of Immunization – all other inquiries.....212-676-2259

Immunization Home Page.....
www.nyc.gov/html/doh/html/imm/immprog.shtml

For other DOHMH inquiries:
Providers should call 866-NYC-DOH1

Free Subscription Order Form

Yes! Add me to the mailing list of the
NYCVACScene

New Subscription m **Address/Name Change only** m

Name

Title

Organization

Address

Telephone

Please fax or mail to:

NYC Department of Health and Mental Hygiene,
Bureau of Immunization
2 Lafayette Street, 19th Floor, CN21
New York, NY 10007
Fax: 212-442-8091

To order free childhood or adult Immunization Cards (providers only), call the NYC Department of Health and Mental Hygiene Provider Access Line at 1-866-NYC-DOH1.

NYCVACSCENE

New York City Department of Health and Mental Hygiene
Bureau of Immunization
2 Lafayette Street, 19th Floor, CN21
New York, NY 10007
212-676-2259
FAX: 212-442-8091

nyc.gov/health

PRST STD
U.S. POSTAGE
PAID
NEW YORK, NY
PERMIT NO. 6174