Example C

Protocol for Administration of Immunization

**Purpose**
To prescribe and administer immunizations in community pharmacies. Most pharmacies are open 7 days a week, including weekday evenings, making it very convenient for patients to be immunized.

**Training**
Current certification of training and current CPR card will be required to participate in this Collaborative Agreement Protocol.

Certification shall include:
2) Vaccine indications, contraindications, and dosage recommendations.
3) Documentation practices and procedures to be followed in administration and storage of vaccines.
4) Examine methods for sharing immunization information with patients, parents of patients and other healthcare professionals.
5) Must demonstrate the hands-on ability to administer vaccines.

**Procedures**
1) Screening for contraindications—If the pharmacist encounters a patient for whom one of the contraindications or precautions is present, the prescriber MUST be contacted prior to administration of vaccines or the patient MUST be referred back to the prescriber without the vaccine having been administered.
2) Emergency Procedures for adverse reactions to vaccines.
   a. Emergency kit containing blood pressure cuff & stethoscope, tourniquet, 2 Epi-Pens (to be prescribed by the authorizing physician).

**Documentation**
The pharmacy will document all immunizations as required by statute, using a standardized documentation form which includes the lot number and expiration date of the vaccine, and on each patient’s personal immunization record. Documentation of immunizations given will be provided to the authorizing physician on a quarterly basis.
Collaborative Agreement Protocol for Immunizations

As a licensed health care provider authorized to prescribe medications in the State of Washington, I authorized _______________________ R.Ph. and other certified registered pharmacists employed at ______________________ to prescribe and administer Influenza, Pneumococcal, travel and other vaccines as mutually agreed, to patients in accordance with the laws (RCW 18.64.001) and regulations (WAC 246-863-100) of the State of Washington. In exercising this authority the pharmacists shall comply with the recommendations of the Advisory Committee on Immunization Practices (ACIP). The pharmacist will document all vaccines administered as required by statute, and on each patient’s personal immunization record. As the authorizing prescriber, I will, on a quarterly basis review the activities of the pharmacist administering vaccines.

This authorization will be in effect for two years, unless rescinded earlier in writing to the Washington State Board of Pharmacy by either party. Any significant changes to the protocol must be agreed upon by the participants and submitted to the Board.

Prescriber Name _______________________________________________

License # ____________________

Prescriber Signature ___________________________________________

Pharmacist Name _______________________________________________

License # _____________________

Pharmacist Signature ___________________________________________