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TIPS ON SAFEGUARDING YOUR VACCINE SUPPLY
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ACUTE UPPER RESPIRATORY INFECTION
(COMMON COLD)

SUBJECTIVE
Sneezing, “stuffiness” of head
Malaise, fatigue Sore throat, cough Poor appetite
Low grade or no fever history

OBJECTIVE
Congested nasal passages
Serous nasal discharge, moist and boggy nasal mucous membranes
Lung fields clear
Low grade fever may be present

ASSESSMENT
Upper respiratory infection (common cold)

PLAN
Acetaminophen for pain or fever
May humidify the air (vaporizer or bathroom shower water) to relieve nasal and
pharyngeal discomfort and cough; vaporizer should not be used if allergic to
molds
Nasal congestion may be relieved as follows by normal saline nose drops. (1/4-1/2
teaspoon salt to 1 cup water) every 4 hours PRN; for infants to 2 years,
recommend suction gently with infant syringe
OTC decongestant as appropriate and if not contraindicated (follow label directions)

Health Teaching:
Instruct patient to rest and force fluids
Teach proper hand washing technique, cover mouth while coughing, and tissue disposal
to prevent spread of disease

Referral Indicators:
 Purulent nasal discharge
 Pharyngeal exudate and/or tender cervical nodes
 Red and/or bulging tympanic membranes
 Tender sinuses
 Fever extending beyond 48 hours/antipyretic does not bring fever below 101° F Infants 0-12
 months with fever 100.5° F rectally
 Infants < 2 months with significant symptoms, with or without fever
 Children under 2 years if no improvement in 24 hours, or signs and symptoms worsen

Follow-Up:
Patient/parent will be asked to contact health provider if condition persist or worsen

Reference:
Mayo Clinic, Guide To Self-Care, Fifth Edition 2006
ASSESSMENT OF IRON INTAKE
AND MANAGEMENT OF IRON DEFICIENCY ANEMIA

Background

Childhood Anemia
Childhood anemia is a very common diagnosis and usually occurs due to an inadequate amount of dietary iron. Adequate iron storage is necessary to prevent anemia, but is also essential for brain development. In order to prevent iron-deficiency anemia, infants should be drinking either breast milk or iron-fortified formula. Toddlers and older children should eat a balanced, iron-rich diet.

Although iron deficiency is the most common etiology, anemia in childhood can be caused by a variety of conditions that are either congenital or acquired. Types of congenital anemia include sickle cell disease or thalassemia; acquired anemia includes such diagnoses as leukemia, gastrointestinal bleeding, and hemolytic disease. Congenital and acquired anemia generally is not iron-responsive. If a child presents with a pre-diagnosed anemia that is NOT iron-deficient, he/she should be referred to his/her provider for further management.

Sickle cell anemia can be easily ruled out by checking the status of the newborn screening. If sickle cell anemia is strongly suspected and an asymptomatic infant’s disease status is unknown, refer to his/her provider, and delay replacement iron regimen until the results are available.

Adult Anemia
Anemia in adults is most commonly due to iron deficiency. In contrast to iron deficiency in childhood, which is most commonly caused by deficient dietary intake, the major cause of iron deficiency anemia is blood loss, which can be overt (trauma, hematemesis, melena, menorrhagia, etc.) or occult (e.g. via the gastrointestinal tract). Iron deficiency can also result from dietary deficiencies or reduced gastrointestinal absorption; however, blood loss should first be ruled out by the patient’s primary care physician as a cause of iron deficiency before nutritional deficiency or malabsorption is assumed as a diagnosis.

Anemia Screening Procedure
Anemia screening is performed by checking hemoglobin levels. Confirm abnormal/low hemoglobin levels with a second test at the same or a new site. Make sure the skin is clean and dry before puncture. Avoid any squeezing of the digit after puncture. After the diagnosis of anemia, iron deficiency anemia is confirmed by administering a therapeutic regimen of iron and demonstrating a rise in hemoglobin of ≥1 g/dL after 4 weeks. If an infant fails to respond to therapy, referral shall be made to the patient’s PCP or to a health department physician or APN for further evaluation.
SUBJECTIVE
Dietary assessment
  - Inadequate consumption of dietary iron
  - Consumption of whole cow's milk or formula with low iron or no iron
  - Children > age 1 year: consumption of more than 24 ounces of milk daily
Menstrual history (if appropriate)
Patient reported history of gastrointestinal blood loss
Normal versus abnormal newborn state screen for sickle cell disease
Symptoms: Pallor, shortness of breath, tachycardia, decreased energy/fatigue/lethargy, dizziness

OBJECTIVE
Fatigued appearance
Pallor of skin and/or conjunctiva
Dyspnea
Tachycardia
Heart murmur
Abnormal/low hemoglobin (hgb), see chart below

<table>
<thead>
<tr>
<th>Age</th>
<th>Criteria for anemia (hemoglobin concentration in g/dL)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-12 months</td>
<td>&lt;11.0</td>
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<td>1-2 years</td>
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<td>8-12 years</td>
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<td>12-15 years (non-pregnant)</td>
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<tr>
<td>Nonsmoker</td>
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<td>&lt;12.5</td>
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<tr>
<td>Smoke up to 1 pack/day</td>
<td>&lt;12.1</td>
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<td>15-18 years (non-pregnant)</td>
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<tr>
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<td></td>
<td>Female</td>
<td>Male</td>
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<td>PREGNANT: 1st Trimester</td>
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<td>Smoke up to 1 pack/day</td>
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<td>Smoke 1-2 packs/day</td>
<td>&lt;11.5</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Smoke &gt;2 packs/day</td>
<td>&lt;11.7</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

**ASSESSMENT**

Not at risk for iron depletion with normal hemoglobin

**OR**

At risk for iron depletion with normal hemoglobin

- Infant at risk: preterm, low birth weight, diet of non-iron fortified infant formula, introduction of cow’s milk prior to 12 months of age, or breastfed infant who is receiving inadequate dietary iron after six months of age
- Toddler/child/adolescent at risk: consumption of more than 24 ounces of cow’s milk daily, low dietary iron intake/picky eaters, previous history of iron deficiency

**OR**

Anemia, suspect iron-deficiency

**PLAN**

For those not at risk for iron depletion with a normal hemoglobin

- Instruct in age appropriate diet high in iron
- Certification for WIC if eligible
- Educate regarding the importance of iron for both blood and brain development
For those at risk of iron depletion with a normal hemoglobin
Instruct in age appropriate diet high in iron
Issue age-appropriate multivitamin with iron or write prescription:
  o Infant/toddler multivitamin with iron drops at dose of 1 ml daily OR
  o Children’s chewable multivitamin with iron at dose of one tablet daily per manufacturer’s directions
  o **NOTE:** If multivitamins with iron are used in an infant who is not anemic, the daily dose should not exceed 15 mg elemental iron daily or 2 mg/kg/day. Most infant/toddler *multivitamin* with iron drops contain 10 mg elemental iron per milliliter. Most chewable multivitamins with iron for toddlers and older children/adolescents contain 15-18 mg elemental iron per tablet. These should be administered according to package instructions.

Give iron-related pamphlet
Certification for WIC if eligible
Educate regarding the importance of iron for both blood and brain development

For those with suspected iron deficiency anemia, see table below and refer to the Iron replacement Dosing Chart:

<table>
<thead>
<tr>
<th>Age &lt;6 months</th>
<th>Age 6-12 Months</th>
<th>Age 1-3 Years</th>
<th>Age 3-12 Years</th>
<th>Age 12-18 Years</th>
<th>&gt;18 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain dietary assessment</td>
<td>Obtain dietary assessment</td>
<td>Obtain dietary assessment</td>
<td>Obtain dietary assessment</td>
<td>Obtain dietary assessment</td>
<td>Evaluate for blood loss (history, physical, hemoccult)</td>
</tr>
<tr>
<td>Instruct to use breast milk or iron fortified formula</td>
<td>Instruct in adequate consumption of dietary iron</td>
<td>Instruct in adequate consumption of dietary iron</td>
<td>Instruct in adequate consumption of dietary iron</td>
<td>Instruct in adequate consumption of dietary iron</td>
<td>Consider referral to MD or NP</td>
</tr>
<tr>
<td>Supplement with iron according to the dose based on body weight (see dosing chart)</td>
<td>Give iron-related pamphlet</td>
<td>Decrease milk if necessary to 16 ounces or less daily</td>
<td>Give iron-related pamphlet</td>
<td>Decrease milk if necessary to 16 ounces or less daily</td>
<td>Decrease milk if necessary to 16 ounces or less daily</td>
</tr>
<tr>
<td>Refer to WIC if eligible</td>
<td>Refer to WIC if eligible</td>
<td>Give iron-related pamphlet</td>
<td>Refer to WIC if eligible (&lt; 5 yrs.)</td>
<td>Give iron-related pamphlet</td>
<td>Give iron-related pamphlet</td>
</tr>
<tr>
<td>Refer to WIC if eligible</td>
<td>Supplement with iron according to dose based on body weight (see dosing chart)</td>
<td>Supplement with iron according to dose based on body weight (see dosing chart)</td>
<td>Supplement with iron according to dose based on body weight (see dosing chart)</td>
<td>Supplement with iron according to dose based on body weight (see dosing chart)</td>
<td>Issue Ferrous Sulfate (FeSO₄) 325mg pills. Take one by mouth three times per day.</td>
</tr>
</tbody>
</table>

**Health Teaching**
Oral iron may cause constipation and turn stool black
Establish regular time for drug administration
Iron drops may harmlessly coat the teeth
Oral iron may interfere with absorption of tetracycline
Vitamin C will enhance absorption
Iron absorption is inhibited by antacids, Vitamin E, eggs, coffee, tea, and milk
ORAL IRON IS A SERIOUS POTENTIAL POISON - Issue safely

**Referral Indicators**

- Premature infant
- Poor weight gain/abnormal growth pattern
- Symptomatic anemia (see “objective” for list of possible symptoms)
- Heart murmur present
- Pregnancy
- Pre-diagnosed anemia that is NOT iron-deficient
- Sickle cell disease and other hemoglobinopathies
- Symptoms of gastrointestinal bleeding (dark tarry stools, blood in toilet bowl or on toilet paper, large amounts of blood passed from the rectum, vomiting blood)
- Special health needs that increase the risk of iron-deficiency (chronic infection, inflammatory disorders, chronic or acute blood loss, restricted diets, use of medications that interfere with iron absorption)
- Parent needs further guidance/education (subjective evaluation by RN/RD)
- Inadequate response to therapy

**CRITICAL VALUES:**

**For ages <5:** Refer immediately for hemoglobin of **8.5 or less** or if the patient is symptomatic

**For ages 5 and up:** Refer immediately for hemoglobin of **10 or less** or if the patient is symptomatic

*For all ages, if the patient is symptomatic, they should be referred to their primary care provider immediately

**Follow-up**

For individuals with normal hemoglobin or iron depletion with normal hemoglobin:
- Screen for anemia at routine intervals during WIC visits and/or preventive care visits (EPSDT exams)

For individuals with suspected iron deficiency anemia:

- Evaluate for compliance to dietary and iron therapy
- Repeat hemoglobin in 4 weeks, confirm at least 1 g/dL increase in hemoglobin
  - **If there less than a 1 g/dL increase in hemoglobin after 4 weeks of iron supplementation,** confirm that the dose is appropriate, there is no dairy overconsumption, and that the patient is compliant. If there are no confounding factors and the hemoglobin has not gone up, refer to health care provider.
If there is at least 1g/dL increase in hemoglobin, continue iron supplementation for 8 weeks after hemoglobin confirmed normal.

Refer to health care provider if compliant infant shows inadequate response to therapy or hemoglobin remains below normal range despite 6-8 weeks of iron supplementation.

Iron Replacement Dosing Chart

All treatment of iron deficiency anemia is two-fold, a diet high in iron rich foods and therapeutic regimens of iron.

If concentrated iron drops, elixir or tablets are used in an infant or child that is anemic, the dose should not exceed 6 mg/kg of elemental iron daily to a maximum of the standard adult dose. Replacement iron doses may be divided into two or three daily doses. Liquid concentrated iron preparations are generally accepted but may not be palatable. If a child refuses to take the prescribed preparation, another may be used as long as the daily dose of elemental iron remains consistent.

All doses referenced in this protocol and on the dosing chart refer to either:

- Concentrated ferrous sulfate drops that contain 15 mg/1.0 ml elemental iron.
- Ferrous sulfate elixir that contain 44 mg/5.0 mL elemental iron.
- 325 mg ferrous sulfate tablets that contain 65 mg elemental iron per tablet.

Instruct the caregiver regarding measurement using calibrated, oral medication syringes. Doses in milliliters require a precise dropper or oral syringe with well-marked increments of 0.1 ml.

Maximizing the dose for body weight is very important.
# Iron Replacement Dosing Chart

<table>
<thead>
<tr>
<th>Weight</th>
<th>IRON DROPS (15 mg / 1.0 ml)</th>
<th>Dosing Script (Write This on Prescription)</th>
<th>ELIXIR (44 mg / 5.0 ml)</th>
<th>TABLETS (65 mg / tablet)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lbs</td>
<td>Kgs</td>
<td>mg elemental iron (ml) po bid</td>
<td>mg elemental iron (ml) po bid</td>
<td>mg elemental iron (ml) po bid</td>
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<td>10</td>
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<td><strong>IRON DROPS (15 mg / 1.0 ml)</strong></td>
<td><strong>ELIXIR (44 mg / 5.0 ml)</strong></td>
<td><strong>TABLETS (65 mg / tablet)</strong></td>
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<td>&gt; 95</td>
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</table>
Writing a Prescription for Iron Replacement
Provider and Pharmacist Prescription Guidance
When writing a prescription for ferrous sulfate, the dosage should be based strictly on the exact weight of the child. Use the following format when writing prescriptions for iron replacement. This format will help to standardize the instructions given to pharmacists and should help minimize dosing errors if the pharmacy needs to provide the medication in another formulation.

<table>
<thead>
<tr>
<th>For liquid iron preparations, write:</th>
<th>Example:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ferrous sulfate drops (15mg elemental iron/1.0 mL) Sig (insert dosing script from dosing chart) #QS 1 month, 3 refills</td>
<td>Ferrous sulfate drops (15 mg elemental iron/1.0 mL) Sig 10.2 mg elemental iron (0.7 mL) po bid #QS 1 month, 2 refills</td>
</tr>
<tr>
<td>Or</td>
<td>Or</td>
</tr>
<tr>
<td>Ferrous sulfate elixir (44mg elemental iron/5.0 mL) Sig (insert dosing script from dosing chart) #QS 1 month, 3 refills</td>
<td>Ferrous sulfate elixir (44 mg elemental iron/5.0 mL) Sig 66 mg elemental iron (7.5 mL) po bid #QS 1 month, 3 refills</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>For iron tablets, write:</th>
<th>Example:</th>
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</thead>
<tbody>
<tr>
<td>Iron tablets (65 mg elemental iron/tablet) Sig (insert dosing script based from dosing chart) #QS 1 month, 3 refills</td>
<td>Iron tablets (65 mg elemental iron/tablet) Sig one tablet (65 mg elemental iron) po tid #QS 1 month, 3 refills</td>
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</table>

REFERENCES


Schrier SL, Mentzer WC. Causes and diagnosis of anemia due to iron deficiency, In: UpToDate, SA (Ed), UpToDate, Waltham, MA, 2011.
BLOOD PRESSURE, ELEVATED
CHILDREN 1-17 YEARS OF AGE

GENERAL INFORMATION

Based on the Fourth Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of Hypertension in Children and Adolescents, the following definitions are provided:

**Normal** BP in children is defined as an average systolic and diastolic BP ≤90th percentile for gender, age and height

**Hypertension** in children is defined as an average systolic BP and/or diastolic BP that is ≥ 95th percentile for gender, age, and height on ≥ 3 separate occasions

**Prehypertension** in children is defined as an average systolic BP or diastolic BP that are ≥ 90th percentile but <95th percentile or a BP that exceeds 120/80 mmHg even if below the 90th percentile

In order to achieve an accurate blood pressure reading, it is recommended that:

- The child be free of stimulant drugs or food **AND**
- Have been sitting quietly for 5 minutes **AND**
- Be seated with his or her back supported, feet on the floor, and right arm supported, cubital fossa at heart level
- The right arm is preferred in repeated measures of BP for consistency and comparison with standard tables; it is also important because of the possibility of coarctation of the aorta, which might lead to false (low) readings in the left arm

PLAN

- Obtain the child’s height and age
- Use a cuff appropriate to the size of the child’s upper arm – BP using auscultation is preferred
- Have child sit quietly for 5 minutes with feet and back supported
- Check BP of any child over 3 years of age using the right arm
- If BP is ≤90th percentile, the BP is normal
- If the BP is > 5 mm Hg above the 99th percentile, **REFER PROMPTLY**
- If the patient is symptomatic, **REFER IMMEDIATELY**
- If automatic BP cuff is used and the child is found to have elevated BP ≥ 90th percentile, repeat BP using auscultation after sitting quietly for 5 minutes
- If BP found to be elevated (≥ 95th percentile) based on systolic and diastolic reading, age, gender and height (using attached chart), repeat BP in one week
- If BP continues to be elevated on the second visit, check BP again in one week
- If the third BP check is still elevated and the average of the 3 BPs is ≥ 95th percentile, **REFER**
Using the BP Chart
1. Obtain height and age of child
2. Measure and record BP
3. Find correct gender chart
4. Find the child’s age on the left side of the chart, follow the age row horizontally across the table to the intersection of the line for the height percentile (vertical column)
5. Find the 50th, 90th, and 99th percentiles for systolic and diastolic BP in the right columns
   - BP < 90th percentile = Normal
   - BP between the 90th and 95th = Prehypertensive
   - BP > 95th percentile X 3 checks = May Be Hypertensive
   - BP > 99th percentile + 5 mm Hg = Probably Hypertensive

Health Teaching
Counsel the child on prevention and health related life-styles such as:
- Weight reduction
- Increased physical activity
- Dietary modification such as decreased sugar, salt, and an increase in fresh fruits and vegetables, regular meals, and a healthy breakfast
If Prehypertensive counsel regarding the need for BP recheck in 6 months

Referral Indicators
BP > 99th percentile + 5 mm Hg (PROMPTLY, if symptomatic IMMEDIATE)
Average of 3 BP > 95th percentile
Symptoms of elevated BP (i.e. headache, blurred vision, vertigo, chest pain, edema, nausea and vomiting, and alteration in consciousness)

REFERENCE

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<th>Age (Year)</th>
<th>BP Percentile</th>
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<th>Diastolic BP (mmHg) ← Percentile of Height →</th>
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BP standards based on sex, age, and height provide a precise classification of BP according to body size.
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BP standards based on sex, age, and height provide a precise classification of BP according to body size
FLUORIDE DEFICIENCY

NOTE:

- The use of dietary fluoride supplements is one alternative means of providing fluoride protection to the teeth of children 6 months old to 16 years of age who consume fluoride-deficient water with 0.6 ppm fluoride or less.

- Dietary fluoride supplements, in the form of daily tablets, lozenges, liquids, or vitamin-fluoride combinations, provide systemic benefits to developing teeth as well as topical benefits to erupted teeth. When practical, supplements should be prescribed as chewable tablets or lozenges to maximize the topical effects of fluoride.

- When prescribed and used appropriately, fluoride supplements provide benefits similar to those obtained from ingesting optimally-fluoridated water over the same period of time.

- **When improperly prescribed, fluoride supplements may cause mild enamel fluorosis (white spots on teeth). Therefore, systemic fluoride supplements should never be prescribed to children in fluoridated communities who are already receiving optimally fluoridated water (0.7-1.2 ppm fluoride).**

- Because of an increase in the milder forms of dental fluorosis associated with fluoride ingestion in excess of that necessary to prevent tooth decay, a conservative approach to fluoride supplementation should be used and in accordance with the recently revised guidelines.

- If a child's primary drinking water source is a well, spring, or non-fluoridated community water system, a water sample must first be taken and analyzed to determine its fluoride content and what dosage of fluoride supplement, if any, is needed.

SUBJECTIVE
No other systemic source of fluoride besides that present in foods and beverages processed with fluoridated water
Request for dietary fluoride supplement
Age 6 months to 16 years

OBJECTIVE
Private community water supply with a fluoride content 0.6 ppm fluoride or below as confirmed by fluoride assay
Dental caries are more common in areas of fluoride deficient water supply.
ASSESSMENT
Fluoride Deficiency

PLAN
Drinking water should be analyzed for fluoride content prior to supplementation in order to determine if supplements are necessary and how much to prescribe.
To determine the level of fluoride in the child’s existing water supply:
1. Obtain water sample bottles from either Fluoridation Specialist (TDEC Nashville Env. Field Office, Division of Water Supply, 711 R.S. Gass Blvd, Nashville, TN 37216, Telephone 615-687-7037 or the Regional Dental Director.
2. Provide parent or guardian with 1 water sample bottle, request slip for fluoride determination.
3. Instruct patient on the correct procedure for collecting and handling of the water sample:
   a. Using a kitchen or bathroom faucet allow cold water to run for at least 30 seconds.
   b. Rinse out the sample bottle twice before filling.
   c. Fill sample bottle with cold water and screw on cap firmly.
   d. Mail the sample within 3 days.

Estimate an effective fluoride concentration as indicated (child is consuming water from multiple sources)

Example: If the home water supply is tested and the fluoride concentration is 0.2 ppm, but it only accounts for half of the child’s daily water intake (0.2 ppm x 0.50 = 0.1 ppm) and the day-care water supply has a known fluoride concentration of 1.0 ppm and it accounts for the remaining half of the child’s daily intake (1.0 ppm x 0.50 ppm) a dietary fluoride supplement (if prescribed) should be based on the effective fluoride concentration of 0.6 ppm and not 0.2 ppm

Issue fluoride supplements according to the following dosage schedule:

<table>
<thead>
<tr>
<th>Dietary Supplemental Fluoride Dosage Schedule in mg F/day</th>
<th>Revised, ADA Winter 1994</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age of Child</strong></td>
<td><strong>ppm fluoride in water supply</strong></td>
</tr>
<tr>
<td></td>
<td>0-0.3 ppm</td>
</tr>
<tr>
<td>Birth to 6 mo</td>
<td>0</td>
</tr>
<tr>
<td>6 mo to 3 yrs</td>
<td>0.25 mg</td>
</tr>
<tr>
<td>3 to 6 yrs</td>
<td>0.5 mg</td>
</tr>
<tr>
<td>6-16 yrs</td>
<td>1.0 mg</td>
</tr>
</tbody>
</table>

Issue on a “one bottle at a time” basis
Each bottle should not exceed the recommended limit of 120 mgs of fluoride
Health Teaching:

There is a well-documented decline in dental caries in children in the United States which is due to widespread use of various forms of fluoride. Even people living in communities where water supplies are not fluoridated still benefit from exposure to fluorides found in toothpaste, mouth rinses, professionally applied fluorides and in foods processed in cities where water supplies are fluoridated (i.e., the “halo” phenomenon).

In order to reduce risk of dental fluorosis, it is recommended that parents closely supervise tooth brushing by young children to prevent their ingestion of fluoride toothpaste and to ensure that only very small quantities (pea-sized amounts) are used. Careful use of fluoride is particularly appropriate during the time of anterior tooth enamel development (birth to 6 years).

Follow-Up:

The parent or guardian of the child will be asked to return for a refill when one bottle is near completion or if the fluoride status of the water supply changes.

Reference

MMWR August 17, 2001 / 50 (RR14) 1-42
MMWR “Achievements….etc.” October 22, 1999 / 48 (41); 933-940
INVASIVE HAEMOPHILUS INFLUENZA TYPE B, DISEASE CONTACT

Background
Before the introduction of effective vaccines, Haemophilus influenza type b (Hib) was the leading cause of bacterial meningitis in the United States among children younger than 5 years old. Widespread use of Hib conjugate vaccine has virtually eliminated invasive Hib disease in the United States and other countries where vaccination is routine. Hib is spread by direct contact with a patient’s oral secretions. Hib can be spread by people who have the bacteria in their noses or throats but who do not show symptoms. The incubation period is unknown.

SUBJECTIVE
Referred to Health Department with history of recent (within 1 week) contact to confirmed case of invasive Haemophilus influenzae type B disease and other resources for patient to purchase medication is not available

OBJECTIVE
Chemoprophylaxis with Rifampin Recommended
For all household contacts in the following circumstances:
- Household with at least 1 contact younger than 4 years of age who is unimmunized or incompletely immunized
- Household with a child younger than 12 months of age who has not completed the primary Hib vaccine series
- Household with a contact who is an immunocompromised child, regardless of that child’s Hib immunization status
For preschool and childcare center contacts when 2 or more cases of Hib invasive disease have occurred within 60 days
For the index patient, if younger than 2 years of age, or a member of a household with a susceptible contact and treated with a regimen other than cefotaxime or ceftriaxone.

Consult with Regional Health Officer as needed for further identification/clarification of contacts needing chemoprophylaxis

Chemoprophylaxis Not Recommended
For occupants of households with no children younger than 4 years of age other than the index patient
For occupants of households where all household contacts 12 through 48 months of age have completed their Hib immunization series and when household contacts younger than 12 months of age have completed their primary series of Hib immunization
For preschool or childcare contacts of one index case
For pregnant women

Observe for symptoms of fever, malaise, nausea, vomiting, severe headache, increased sensitivity to light, altered mental status or confusion.

IF SYMPTOMATIC DO NOT PROVIDE PROPHYLAXIS, REFER IMMEDIATELY FOR DEFINITIVE DIAGNOSIS AND TREATMENT
ASSESSMENT
Provide chemoprophylaxis and immunization as indicated

PLAN
Rifampin is the drug of choice for chemoprophylaxis
Obtain order from health department physician to issue Rifampin (for individual with no known allergy to Rifampin)
Obtain Rifampin from regional pharmacy; ask regional pharmacist to re-package tablets for adults and mix suspension for children; if necessary, Rifampin may be provided to a local pharmacist for re-packaging

Rifampin Dosage:
Adults: 600 mg/day (single dose) x 4 days, by mouth
Children (1 month-12 years): 20 mg/kg/day (single dose) x 4 days, not to exceed 600 mg per dose, by mouth
Infants (less than 1 month): 10 mg/kg/day (single dose) x 4 days, by mouth

Instruct patient regarding medication side effects and contraindications

Immunization
Children in the household and younger than age 5 years who are incompletely immunized against Hib disease according to the Hib immunization schedule should be administered a dose of Hib-containing vaccine and, if necessary, educated to return for the next dose when due. A single dose of Hib vaccine completes the series for any child age 15 months through 59 months.

Health Teaching
Advise barrier method (foam and condoms) for oral contraceptives
Advise contact lens wearers that tears will be orange and stain contacts; urine may be orange
Notify Regional Health Officer, Communicable Disease Director and Nursing Supervisor

Referral Indicators:
Symptomatic for meningitis
Unable to tolerate, or allergy to, Rifampin

REFERENCES
CDC. Meningitis – Bacterial
www.cdc.gov/meningitis/bacterial
Epidemiology and Prevention of Vaccine-Preventable Diseases, Department of Health and Human Services, Centers for Disease Control and Prevention, 12th Edition, May 2011
Yeh, S. Prevention of Haemophilus influenza infection. In: UpToDate, Torchia, M (Ed), Waltham, MA, 2013
MENINGOCOCCAL, INVASIVE DISEASE, Contact

BACKGROUND
Invasive infections with *Neisseria meningitidis* may present as meningococcemia (an infection of the bloodstream), meningococcal meningitis (inflammation of the protective membranes that cover the brain and spinal cord), or both. Invasive meningococcal disease is rare (about 1,000 cases occur in the United States each year) and serious. About 10% of cases die. Among survivors, 11-20% suffer neurologic damage or loss of limbs. Invasive meningococcal disease is spread person to person through exchange of respiratory and throat secretions such as coughing, kissing or sharing eating utensils. The incubation period of meningococcal disease is 1-10 days, usually less than 4 days. Meningococcal vaccines cannot prevent all cases of meningococcal disease and is not a factor in decisions concerning chemoprophylaxis of contacts.

SUBJECTIVE
Referred to Health Department with history of exposure to confirmed case of invasive meningococcal disease within 7 days of onset of disease in the index case and less than 2 weeks after exposure and other resources not available for patient to purchase medication.

OBJECTIVE
Chemoprophylaxis recommended (high risk)
Chemoprophylaxis is indicated for the following close contacts, ideally within 24 hours of diagnosis of *Neisseria meningitidis* invasive disease in the index case, but not more than 2 weeks after exposure.
- Household members, roommates, intimate contacts in the 7 days prior to disease onset
- Child care or preschool contacts any time during 7 days before onset of illness
- Direct exposure to index patient’s oral secretions through kissing or through sharing toothbrushes, cigarettes, drinks or eating utensils, markers of close social contact, at any time during 7 days before onset of illness.
- Mouth-to-mouth resuscitation, unprotected endotracheal intubation or endotracheal tube management during 7 days before onset of illness
- People who frequently slept in the same dwelling as index patient during 7 days before onset of illness
- Passengers seated directly next to the index patient during airline flights lasting more than 8 hours

Consult with Regional Health Officer as needed for further identification/clarification of contacts needing chemoprophylaxis

Observe for symptoms of fever, malaise, nausea, vomiting, severe headache, increase sensitivity to light, altered mental status or confusion

IF SYMPTOMATIC, DO NOT PROVIDE PROPHYLAXIS, REFER IMMEDIATELY FOR DEFINITIVE DIAGNOSIS AND TREATMENT
ASSESSMENT
Provide chemoprophylaxis as indicated

PLAN
Obtain order from health care provider to issue Rifampin (no known allergy to Rifampin)

Obtain Rifampin from regional pharmacy; ask regional pharmacist to repackage tablets for adults and mix suspension for children

Rifampin:
- **Adults:** 600 mg every 12 hours x 2 days
- **Children: (1 month-12 years)** 10 mg/kg/dose every 12 hours x 2 days not to exceed 600 mg/dose
- **Infants: (less than 1 month)** 5 mg/kg/dose every 12 hours x 2 days

**Ciprofloxacin:** 500 mg STAT dose may be issued or prescribed as an alternate treatment for persons over age 18 years

Health Teaching
Counsel patient that chemoprophylaxis is not 100% protective, review the signs and symptoms of meningococcal disease (sudden onset of fever, chills, malaise, muscle pain or a rash), advise to seek immediate medical attention should these signs develop.
Instruct patient regarding side effects and contraindications of chemoprophylaxis
Advise barrier method (foam, film or condoms) for oral contraceptive clients
Advise that tears will be orange and stain contacts lenses; urine may be orange
Notify regional health officer, communicable disease director and nursing supervisor
Should check to see that index case received Rifampin post treatment to eradicate upper respiratory tract colonization of organism

Referral Indicators:
- Symptomatic for meningitis
- Unable to tolerate Rifampin

REFERENCES

CDC. Meningococcal Disease
[www.cdc.gov/meningococcal/about/symptoms.html](http://www.cdc.gov/meningococcal/about/symptoms.html)
Epidemiology and Prevention of Vaccine-Preventable Diseases, Department of Health and Human Services, Centers for Disease Control and Prevention, 12th Edition, May 2011

Immunization Action Coalition, Meningococcal: Questions and Answers Information about the disease and vaccines, March 2012

Kaplan SL, & Pentima CD. Meningitis in Children Beyond the Basics, In: UpToDate, Torchia, MM (Ed), Waltham, MA, 2013
TUBERCULOSIS, CASE OR SUSPECT (INITIAL VISIT)

SUBJECTIVE
Symptoms may include the following:
- Cough >2 weeks
- Hemoptysis
- Chest pain
- Fever
- Referral from physician
- Chills
- Night sweats
- Weight loss
- Fatigue

OBJECTIVE
Productive cough
Thin, pale
HIV status
Positive or negative tuberculin skin test (TST)
Positive, negative or indeterminate IGRA (Indeterminate should be repeated)
Positive or negative smear, cultures, or culture pending
Abnormal chest X-ray
Other diagnostic tests/results
Baseline measurement from TB clinic to include CMP, CBC with platelets and differential, and HIV. (Routine laboratory monitoring for toxicity is generally not needed in individuals with normal baseline.)
Clinical information from other providers, hospital

ASSESSMENT
Tuberculosis suspect (culture report not available)
Tuberculosis case (culture report or nucleic acid amplification test result is positive, indicate site of infection)
Latent Tuberculosis Infection (LTBI)

PLAN
Have patient wear surgical mask if symptomatic; nurse must wear n-95 mask

Initial Nursing Assessment:
Face to face contact will be made within 24 hours of notification of new infectious (sputum smear positive or cavitary on chest x-ray) TB suspect/case; this contact may be in the home, office, hospital, or other facility
Explain contact investigation and begin identifying contacts
Face to face contact visit will be made within 3 working days of notification of a newly diagnosed case or suspect who is:

- sputum smear negative,
- culture pending or culture positive,
- abnormal chest x-ray non-cavitary

Records should be obtained within 24 hours of report of suspect

**Conduct Home Assessment:**
If the initial visit is not a home visit, nurse should make a home visit to assess the home environment within 3 working days from notification; preferably the home visit should be made prior to patient’s discharge from hospital, but no later than 24 hours after discharge from a hospital (see TB Guidelines)

Nurse must ensure that no immunosuppressed persons or children <4 years of age are in the home if an infectious patient is being discharged home

**Provide Screening Evaluation:**
Consider psychosocial, cultural background, and language/literacy level
Provide interpreter services as needed
Complete TB/LTBI Risk Assessment Tool (if not done previously) and evaluate history, including onset and duration of symptoms and signs for TB (as listed above)
Evaluate for possible pregnancy
Screen for any contraindications to anti-tuberculosis drugs (using PH 2040, Screening and Monitoring Forms)
Observe patients and family’s ability and availability of resources to cope, adherence to medications regimen, and compliance with follow-up
If being treated by private physician, obtain record of physical exam, chest X-ray report, significant lab tests (sputum cultures, liver functions, and WBC) and medication orders
Ascertain whether MD will follow or if Health Department to follow; if Health Department to follow, refer to TB Clinic
Assure that a focused physical exam and chest X-ray have been performed by TB clinic MD/NP; if not done, refer back to TB clinic
Begin contact investigation
If patient is hospitalized, notify hospital of isolation discharge requirements
If patient is discharged from hospital, obtain and send copy of all records (notes, lab, and radiology reports, physician orders, and medication sheets) to regional TB clinic

**Obtain and Document the Following Information:**
Physician referral of suspect, case, or orders for anti-TB drugs
Known contacts
HIV status/other TB risk factors
PPD skin test history (including measurement) or previous IGRA test (including dates and results)
Previous history of –
  - Tuberculosis disease
  - TB infection (LTBI)
  - Administration of anti-TB medications
Symptoms including –
  - Date of first symptom
  - Weakness, weight loss, anorexia
  - “Flu-like” episode, chills, fever
  - Productive cough, chest pain, blood in sputum
  - Night sweats
Other health problems including –
  - HIV or immunosuppression
  - Diabetes mellitus
  - Liver or kidney disease
  - History of alcohol or drug abuse
  - Current medications (including OTCs and herbal medicines)
  - LMP
  - Allergies
  - Other evaluation by private MD, other providers, or health care facility
  - Special patient needs

**Treatment:**
Instruct on home isolation precautions until no longer infectious, or place patient on isolation if indicated
Measure height, weight, and vital signs initially.
Obtain weight and vital signs monthly
**Directly observed therapy (DOT) is the standard of care for all TB cases**
Issue anti-tuberculosis drugs as prescribed by TB clinic physician (only those medications approved by TB clinic MD may be issue)
If on ETHAMBUTOL perform visual acuity (Snellen chart) and Red/Green color discrimination monthly; if patient wears glasses, check vision with glasses and note this in record
If STREPTOMYCIN or an AMINOGLYCOSIDE (Capreomycin, Amikacin) is to be used, obtain BUN and creatinine; patient should be questioned at baseline and monthly about possible hearing loss or tinnitus, and monitor vestibular function using the Romberg at baseline and monthly
At treatment initiation, if not drawn in TB clinic, draw CMP, CBC with platelets and differential
and HIV (if not known); all labs to be reviewed by the TB physician
Issue 3 sputum containers, dated and numbered (if pulmonary TB or to rule out pulmonary TB) with instructions for collecting in AM
Collect first sputum specimen in clinic in person by sputum induction using 3% sodium chloride.
Issue patient 2 prelabeled and dated cans for use the next 2 consecutive days for natural sputum collection
Complete all required fields on lab requisition
DOT worker should pick up sputums at home on the day of collection for mailing to the lab from the local health department

Perform Contact Investigation (see TB Guidelines)
All high-risk contacts should be tested within 7 working days
Completion of initial medical assessments of high-risk contacts should be completed within 10 working days of contact identification.
Document all contact information on PH 1631, “TB Contact Record”

NOTE: IGRA test is preferred for baseline testing for contacts ≥5 years of age.
All contacts should receive an IGRA or TST if they have a documented negative PPD or IGRA history.

All high-risk contacts (from all environments) that have a positive IGRA or Positive TST are to have a chest X-ray and evaluation by an MD or APN.
Contacts that have an initial negative TST or IGRA but are at risk of progression to active TB (i.e., children < 4, immunosuppressed persons, pregnant women, dialysis patients, HIV+, etc.) are to have a chest X-ray and evaluation by an MD or APN as soon as possible.

All contacts with an initial negative IGRA or TST should have a repeat IGRA or TST at 8-10 weeks after contact is broken (last exposure) with the suspect/case; only one IGRA or TST is needed if contact has been broken for more than 10 weeks when initially tested.

NOTE: Use consistent method of testing for evaluation of a contact
Example:
  o if IGRA is drawn initially, then at 8-10 weeks, IGRA will be repeated
  o if Tubersol PPD is placed initially, then at 8-10 weeks, a second PPD will be placed using Tubersol
  o if Aplisol PPD is placed initially, then at 8-10 weeks, a second PPD will be placed using Aplisol
Any contact that has an indeterminate IGRA is to be retested within 1-2 weeks.
Consult with regional TB nurse/physician for preventative therapy on ALL children who are close contacts of infectious or potentially infectious cases of TB, regardless of skin test results.
Document on contact record (PH 1631). When contact investigation is completed, send a copy of PH 1631 to Regional TB office.

**Provide Follow-up**

If patient is being followed by Health Department TB physician, schedule monthly return appointments to TB clinic.

If patient is being followed by a private provider, schedule monthly visit with PHN to issue medication(s) and document any medication side effects.

Obtain monthly office visit medical record notes from private provider prior to monthly PHN visit at health department.

For patients with active TB:
- Ensure DOT as ordered by **physician** until regimen is completed
- Assess for side effects each time DOT is given
- Weigh at every TB clinic visit
- Ensure baseline labs and sputum culture results are in chart
- Report any symptoms suggesting toxicity promptly to the treating **physician** and obtain appropriate lab specimens as ordered
- If on ETHAMBUTOL, perform monthly vision checks including visual acuity and color red/green discrimination
- If on STREPTOMYCYCIN or an AMINOGLYCOSIDE (Capreomycin, Amikacin), perform monthly Romberg and hearing evaluation (see TB Guidelines)
- Repeat liver testing if indicated (underlying liver disease, alcohol use symptoms) or as ordered by physician
- Issue sputum containers (set of 3) at least monthly but should be more frequently if patient is infectious; three sputum cultures must be obtained at one month and two months as ordered by **physician** (document reason if unable to obtain and notify Regional TB clinic), remind physician to order at 2 months if not done
- Sputum cultures must be done every month until patient has 3 consecutive negative cultures for 2 consecutive months
- When culture sent to outside labs, contact private provider or lab to ensure culture and sensitivity are ordered and that culture isolate is sent to state lab
- Send a copy of completed drug monitoring sheet to the regional TB clinic monthly
- Ensure TB clinic is aware of all culture and sensitivity results

**Provide Referral:**
- Current medication intolerance and/or adverse reactions
- Abnormal laboratory findings
- Pregnancy
- Non-adherence
REFERENCES


CDC. Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis: Recommendations from the National Tuberculosis Controllers Association and CDC. MMWR 2005; 54 (No. RR-15, 1-37)


CDC. Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium tuberculosis Infection — United States, 2010. MMWR 2010; 59 (RR-5); 1-25


Report of the Committee on Infectious Diseases. Elk Grove Village, IL

Tennessee Department of Health Tuberculosis Guidelines, 2004
RABIES VACCINE, PRE-EXPOSURE

Preexposure vaccination and post-vaccination serology and booster vaccination are generally not given by health department personnel. If provided, the Regional Health Officer or Regional Medical CEDS Director should be notified to approve administration prior to the health department implementation.

General Information

Appropriate candidates for the primary course of pre-exposure rabies vaccination include those persons who are associated with a professional or recreational activity that places them at risk for contact with rabies virus according to the recommendations of the Advisory Committee on Immunization Practices (ACIP).

Persons considered to be at continuous risk (e.g., rabies research laboratory workers, rabies biologics production workers) are advised to receive the primary course and have serologic testing every 6 months. A booster vaccination is given if antibody titer is below the acceptable level as reported by the laboratory.

Persons considered to be at frequent risk (e.g., spelunkers, veterinarians and staff and animal-control and wildlife workers in rabies-enzootic areas) are advised to receive the primary course and have serologic testing every 2 years. A booster vaccination is given if antibody titer is below the acceptable as reported by the laboratory.

Persons considered to be at infrequent risk (e.g., Veterinarians and animal-control and wildlife workers in areas with low rabies rates, veterinary students, travelers visiting areas where rabies is enzootic and immediate access to appropriate medical care including biologics is limited) should receive the primary course. No serologic testing or booster vaccination is recommended.

According to current ACIP guidelines post-vaccination serology and booster vaccination for persons at continuous or frequent rabies risk are indicated. Serology should be based on rapid fluorescent focus inhibition test (RFFIT). RFFIT testing and submission guidelines are available from:

- Kansas State University College of Veterinary Medicine Rabies Laboratory (785-532-4483), http://www.vet.ksu.edu/DEPTS/dmp/service/rabies/rffit.htm
- Atlanta Health Associates (770-205-9091 or 800-717-5612), http://www.atlantahealth.net/

A booster is indicated if the titer is less than complete neutralization at a 1:5 serum dilution by the RFFIT as reported by the testing laboratory. Contact the State Public Health Veterinarian for additional consultation.
VACCINATION PLAN FOR PRIMARY COURSE (PREVIOUSLY UNVACCINATED):

- Review patient history for pre-exposure vaccination or post-exposure prophylaxis and contraindications (previous severe reaction, pregnancy, concurrent use of chloroquinemphosphate for malaria prophylaxis, immunosuppression)
- Reconstitute vaccine per manufacturer’s directions.
- Administer 1 ml of rabies vaccine (Human Diploid Cell Vaccine [HDCV / Imovax] or Purified Chick Embryo Cell Vaccine [PCEC / RabAvert]) on days 0, 7, 21 or 28; given IM per manufacturer’s directions
- Instruct patient to remain in clinic for 20 minutes following vaccination (observe for possible reaction)

Health Education:
Discuss adverse reactions such as mild to moderate inflammatory reactions, as well as infrequent mild systemic reactions such as headache, nausea, abdominal pain, muscle aches, dizziness
Be sure that the client understands the importance of keeping return appointment dates
Return for 2nd (day 7) and 3rd dose (day 21 or 28) according to schedule

PLAN FOR SEROLOGY AND BOOSTERS (PREVIOUSLY VACCINATED):

- Review patient history for pre-exposure vaccination or post-exposure prophylaxis.
- Conduct and review results of RFFIT. Guidance on submission of serum should be obtained from the laboratory performing the test or the Tennessee State Public Health Veterinarian.
- If a booster is indicated, review contraindications (previous severe reaction, pregnancy, concurrent use of chloroquine phosphate for malaria prophylaxis, immunosuppression)
- Reconstitute vaccine per manufacturer’s directions.
- Administer 1 ml of rabies vaccine (Human Diploid Cell Vaccine [HDCV / Imovax] or Purified Chick Embryo Cell Vaccine [PCEC / RabAvert]) on day 0; given IM per manufacturer’s directions
- Instruct patient to remain in clinic for 20 minutes following vaccination (observe for possible reaction)

Health Education:
Discuss adverse reactions such as mild to moderate inflammatory reactions, as well as infrequent mild systemic reactions such as headache, nausea, abdominal pain, muscle aches, dizziness

References:
CHLAMYDIA TRACHOMATIS, CONTACT PARTNER DELIVERED THERAPY

NOTE: In 2002 the Board of Medical Examiners and the Board of Osteopaths adopted an amendment to the medical practice act allowing providers and those who provide medical services under their responsibility and control to use partner delivered therapy.

The following protocol should be implemented as an important DISEASE CONTROL STRATEGY and in accordance with CDC recommendations.

SUBJECTIVE
Partner delivered therapy is for those contacts to index cases of chlamydia who are unlikely to seek medical care.

OBJECTIVE
A laboratory confirmed Chlamydia infection without evidence of co-infection with gonorrhea or other complications suggestive of a relationship to Chlamydia infection
Provision of treatment of the (index) patient for Chlamydia
An attempt to persuade the infected patient to have all partners evaluated and treated and indication from the patient that partner(s) would not comply

PLAN
Document objective findings in index patient’s record.

Provide a Chlamydia fact sheet to the patient with copies for all partners.

Counsel the patient on sexual abstinence for seven days after treatment and until seven days after partners have been treated.

Provide to the treated patient a non-named signed (MD or NP) prescription(s) or a signed, name-specific prescription(s) OR

Issue to the treated patient 1 gram of azithromycin for each of the unnamed sex partners or for each of the total number of known sex partners named by the patient.

Refer to PHN Protocol 5.010 for Chlamydia Case or Contact for treatment and counseling.