ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.43	Page 1 of 7
	Effective Date: June 15, 2019	
	Distribution: A	
	Supersedes: 113.43 (11/15/16)	
Approved by: Tony Parker		
Subject: IMMUNIZATIONS: INMATE POPULATION		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To enhance prevention of vaccine-preventable diseases.

III. APPLICATION: Wardens, Superintendents, health administrators, job coordinators, health care staff, inmates, and privately managed institutions.

IV. DEFINITIONS: None.

V. POLICY: Immunizations shall be administered to inmates in accordance with immunization regulations and instructions published by the Tennessee Department of Health and the Centers for Disease Control (CDC).

VI. PROCEDURES

A. General: Immunizations administered by health care personnel shall be pursuant to physician's orders, Tennessee Department of Correction (TDOC) policy, and be consistent with the immunization recommendations of the Tennessee Department of Health. Employees in state operated facilities are provided immunization in accordance with Policy #113.13.

B. Tetanus Diphtheria Toxoid (Td):

1. All inmates entering the TDOC system shall receive a tetanus diphtheria toxoid (Td) booster. Prior to the administration of any injection, the inmate shall be asked if he/she has any known allergies or other known reason why he or she should not be given a Td. The initial Td booster shall be documented in the appropriate space on the Health History, CR-2007, and on the Immunization/TB Control Record, CR-2217. (See Policies #113.20 and #113.44)

2. Td boosters shall be offered every ten years and given to inmates on a voluntary basis; however, any refusal must be documented in the health record using the Release from Medical Responsibility, CR-1984. (See Policy #113.51)

C. Pneumococcal Vaccines: Inmates shall be administered the pneumococcal vaccines on an individual basis, in accordance with the Tennessee Department of Health's written guidelines and as deemed clinically appropriate by the physician.

D. Influenza Vaccine: All inmates within the custody of TDOC must be offered the influenza vaccine. Specific criteria for the assessment, administration and recording of the vaccine are contained in the *Tennessee Department of Correction, Clinical Services Influenza Preparedness Plan.*

E. Hepatitis A and B: Inmates who are diagnosed with the Hepatitis A or B virus will be treated by the physician in accordance with the current guidelines published by U.S. Department of Health and Human Services Centers for Disease Control. (See Policy #113.42)

F. Inmate Workers/Hepatitis B Vaccine: If an inmate is assigned to a job where duties place him/her at a significant risk of exposure to the Hepatitis B virus, the TDOC may provide on a case by case basis the Hepatitis B vaccine. Annually, the institutional job coordinator shall send the listing of duties for each job at that institution to the health administrator. The health administrator shall reserve the institutional infection control coordinator to determine if any of the institutional job duties place the inmate at significant risk of exposure to Hepatitis B. If a job duty is identified as placing an inmate at significant risk, the health services staff shall make the Hepatitis B vaccine available to inmates who perform that job. The health administrator, in collaboration with the job coordinator, shall establish written institutional procedure(s) for notifying health services staff of those inmates who should be offered the Hepatitis B vaccine. The Hepatitis B vaccine series shall be administered by health care personnel only on a physician's order~~s~~ which follow the appropriate vaccination administration pre-screening and inmate consent using Initial Evaluation Prior to Job Assignment, CR-3499.

G. Work release: Inmates shall obtain in the community and at their own or their employer's expense necessary immunizations. It shall be the work release inmate's responsibility to provide the institutional health administrator with written documentation for each inmate's medical file, prior to job assignment.

VII. ACA STANDARDS**:** 4-4354 and 4-4356.

VIII. EXPIRATION DATE: June 15, 2022.

TENNESSEE DEPARTMENT OF CORRECTION

EXPOSURE CONTROL

INITIAL EVALUATION PRIOR TO JOB ASSIGNMENT

_____
INSTITUTION/DISTRICT/DIVISION

CONFIDENTIAL

The following criteria regarding occupational/medical history and medical problems, which could interfere with the ability to use protective clothing, equipment, or the receipt of the Hepatitis B Virus (HBV) vaccination has been reviewed.

Any **YES** Response – **DO NOT** Give Vaccine

		YES	NO
1.	Are you allergic to yeast? (Baker's yeast?)	_____	_____
2.	Have you *ever* had a serious reaction (anaphylaxis) to previous dose of Hepatitis B vaccine?	_____	_____
3.	Are you currently moderately/severely ill with/without fever?	_____	_____

_____ Does/ Does Not meet the criteria for receiving the HBV vaccination.
Name

_____ _____
Legal Signature/Professional Title of Health Care Provider *Date*

PART I. HEPATITIS B VACCINE CONSENT

I, _____ received HBV training and had the opportunity to
(Employee Name - please print)

ask questions and understand the benefits and risks of Hepatitis B vaccination. I fully release and discharge the State of Tennessee, to employees and agents from any liability for illness, injury, loss or damage that may result therefrom, to the extent remitted by law.

_____ _____
Employee Signature Date

_____ _____
Witness Signature Date

HBV VACCINATION SCHEDULE

	DATE	DRUG NAME	LOT NO.	ADMINISTERED BY (Signature / Title)
First Dose	_____	_____	_____	_____
Second Dose	_____	_____	_____	_____
Third Dose	_____	_____	_____	_____

Post-vaccination serum titer results _____ Date: _____

Employee Hepatitis B Vaccination schedule is:

1ST DOSE	2ND DOSE	3RD DOSE
Date: _____	Date: _____	Date: _____

TENNESSEE DEPARTMENT OF CORRECTION

EXPOSURE CONTROL

INITIAL EVALUATION PRIOR TO JOB ASSIGNMENT

_____

INSTITUTION/DISTRICT/DIVISION

CONFIDENTIAL

PART II. HEPATITIS B VACCINE REFUSAL

STAFF MUST SIGN THE FOLLOWING IF HEPATITIS B VACCINATION IS REFUSED.

I, _____ understand that due to my occupational exposure

(Employee Name - please print)

To blood, or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated, at no charge to myself, with the Hepatitis B vaccine. However, I decline the Hepatitis B vaccination at this time. I also understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can, at no charge to me, receive the Hepatitis B vaccination series.

☐ I have received the Hepatitis B vaccine series.

☐ Other: _____

_____ _____

Name - Signature Date

_____ _____

Witness Signature Date

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number _____

_____
INSTITUTION

SS# _____ **Sex** _____ **Age** _____ **D.O.B.** _____

Next of Kin: Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: **Area Code** _____ **Number** _____

Date Completed: _____ Month _____ Day _____ Year

Height: _____ Weight: _____ Hair Color: _____ Color of Eyes: _____

Blood Pressure (Sitting): _____ Temp: _____ Pulse _____ Resp. _____

DATE, if done on Admission	
Serology _____	EKG _____
Urinalysis _____	Chest X-Ray _____
CBC _____	Hemocult _____
Chem. Scan _____	
Td Booster _____	
Other _____	

ALLERGIES: _____

Date or TB Skin Test _____

Date Read _____ Results _____
(Record in MM.)

Visual Acuity (Snellen) **R.** _____ **L.** _____

CURRENT MEDICATIONS: (Specify drug, strength, dosage form and frequency)

_____

_____

_____

_____

_____

_____

_____

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number _____

1. Family History: Have any of your family or relatives had any of the following? If so, specify who:

Heart Disease	_____	Tuberculosis	_____	Cancer	_____
Sickle Cell	_____	Diabetes	_____	Seizures	_____
Hypertension	_____	Mental Illness	_____	Other	_____

Substance Use _____ Are your parents still alive? _____

2. Social History:

Highest Grade Completed _____ Usual Occupation _____ Marital Status _____

Previous Incarcerations _____ Old Number (TN, Other State, Federal) _____

Prior to Incarceration: _____

Used alcohol: Yes _____ No _____ If yes, Daily _____ Weekly _____ Rarely _____

Other habit forming drug(s) Yes _____ No _____ Name(s) of Drug(s) _____

Ever injected drugs (even once)? Yes _____ No _____

3. When did you last see a doctor? _____

For What Reason: _____

4. Have you ever been told by a doctor that you now have or have had any of the following:
Answer questions by checking **yes** or **no**

NO		YES	COMMENT(S)
☐ a.	Rheumatic Fever	☐	_____
☐ b.	Heart trouble	☐	
☐ c.	High Blood Pressure	☐	_____
☐ d.	Thyroid trouble or Goiter	☐	
☐ e.	Diabetes	☐	_____
☐ f.	Kidney infections or Stones	☐	
☐ g.	Jaundice, hepatitis or liver disease	☐	_____
☐ h.	Ulcer	☐	
☐ i.	Pneumonia	☐	_____
☐ j.	Tuberculosis	☐	
☐ k.	Gallbladder Disease	☐	_____
☐ l.	Sexually Transmitted Infection/Disease (Venereal Disease)	☐	_____
☐ m.	Asthma	☐	
☐ n.	Emphysema	☐	_____
☐ o.	Anemia	☐	
☐ p.	Hemophilia	☐	_____
☐ q.	Cancer	☐	
☐ r.	Epilepsy or Seizure disorder	☐	_____
☐ s.	Allergies, (if yes, what? _____)	☐	
☐ t.	Any other serious illness, or injuries, operations or hospitalizations?	☐	_____
☐ u.	Any history of treatment in a Mental Health Clinic or Psychiatric Hospital?	☐	
☐ v.	Any history of Substance Use Treatment either in or out patient?	☐	_____

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number _____

Hospitalizations

DATE	NAME OF HOSPITAL	LOCATION	REASON

Surgical History

DATE	TYPE OF SURGERY	HOSPITAL/SURGICAL CTR	SURGEON

		NO	YES	COMMENT(S)
5.				
☐ a.	Has there been any change in your weight in the past year? 1. Lost ☐ How much? _____ 2. Gain ☐ How much? _____		☐	
☐ b.	Have you ever had excessive anxiety/nervousness, depression or worrying?		☐	
☐ c.	Have you noticed a change in size or color of any wart or mole, or the appearance of a new one?		☐	
☐ d.	Any itching, skin rash or boils?		☐	
☐ e.	Do you use tobacco?		☐	
☐	1. Chew		☐	
☐	2. Pipe		☐	
☐	3. Cigars		☐	
☐	4. Cigarettes		☐	
	5. How many cigars, cigarettes, or pipes do you smoke in 24 hours? _____			
6.	**HEAD AND NECK**			
☐ a.	Do you have dizzy spells?		☐	
☐ b.	Do you have frequent headaches?		☐	
	How often? _____ What medicine helps your headaches? _____			
☐ c.	Do you have any lumps or swelling in your neck, armpits, groin or other areas?		☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number _____

NO		YES	COMMENT(S)
7.	**EYES**		
☐ a.	Do you wear glasses or contact lens?	☐	
.	For how long? _____		
☐ b.	Do you see double?	☐	
☐ c.	Do you ever see colored halos around lights?	☐	
☐ d.	When your eyes were last examined?	☐	
☐ e.	Do you have trouble seeing objects at a distance or near objects such as a newspaper?	☐	
☐ f.	Do you have vision in both eyes?	☐	
8.	**EARS**		
☐ a.	Do you have difficulty hearing?	☐	
☐ b.	Have you had any earaches lately?	☐	
☐ c.	Do you have repeated buzzing or ringing in your ears?	☐	
☐ d	Do you have a hearing aid(s)?	☐	
9.	**MOUTH, NOSE AND THROAT**		
☐ a.	Do you have any trouble with your teeth or gums?	☐	
☐ b.	When did you last see a dentist?	☐	
☐ c.	Have you ever had sinus problems?	☐	
☐ d.	Does your nose ever bleed for no reason at all?	☐	
☐ e.	Is your voice more hoarse now than in the past?	☐	
10.	**RESPIRATORY**		
☐ a.	Do you have a chronic cough?	☐	
☐ b.	Do you cough up any material?	☐	
☐ c.	Ever have trouble getting your breath after climbing one flight of stairs or walking one city block?	☐	
☐ d.	Do you have frequent colds or influenza attacks?	☐	
☐ e	Do you have sleep apnea?	☐	
☐ f.	Do you use a CPAP/BiPAP Machine?	☐	
11.	**CARDIOVASCULAR**		
☐ a.	Ever get pains or tightness in your chest?	☐	
☐ b.	Ever been bothered by a racing heart?	☐	
☐ c.	Do you have shortness of breath while doing your usual work?	☐	
☐ d.	Need more pillows at night to breathe?	☐	
☐ e.	Do you have swollen feet and ankles?	☐	
☐ f.	Do you use a lot of salt on your food?	☐	
☐ g.	Do you have a pacemaker?	☐	
☐ h.	Do you have a defibrillator?	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number _____

NO			YES	COMMENT(S)
12.		**DIGESTIVE**		
☐	a.	Do you suffer discomfort in the pit of your stomach?	☐	
☐		1. Nausea	☐	
☐		2. Vomiting	☐	
☐		3. Indigestion	☐	
☐		4. Heartburn	☐	
☐	b.	Is it painful or difficult for you to swallow liquids or solid foods?	☐	
☐	c.	Do you have trouble with bowel movements?	☐	
☐		1. Hemorrhoids	☐	
☐		2. Bleeding	☐	
☐		3. Constipation	☐	
☐		4. Diarrhea	☐	
☐		5. Bloody or Black Stools	☐	
☐		6. Rectal Pain	☐	
13.		**URINARY**		
☐	a.	Frequently get up at night to urinate?	☐	
☐	b.	Ever had burning or pains when urinating?	☐	
14.		**MUSCULOSKELETAL**		
☐	a.	Have stiff or painful muscles or joints?	☐	
☐	b.	Are your joints ever swollen?	☐	
☐	c.	Have you ever had any broken bones?	☐	
☐	d.	Have difficulty bending or moving?	☐	
15.		***FOR MALES ONLY***		
☐	a.	Is your urine stream very weak and slow?	☐	
☐	b.	Has a doctor ever told you that you have prostate trouble?	☐	
☐	c.	Ever had discharge from your penis?	☐	
☐	d.	Do you have any pain, swelling, sores or lumps on your testicles or penis?	☐	
16.		***FOR FEMALES ONLY***		
☐	a.	Have you had a hysterectomy?	☐	
☐	b.	Are your menstrual periods regular? Date of last menstrual period: _____	☐	
☐	c.	Ever have pain with your periods?	☐	
☐	d.	Do you have excessive bleeding during your period?	☐	
☐		1. Between periods?	☐	
☐		2. After sexual relations?	☐	
☐		3. After going through the “change of life”?	☐	
☐	e.	What type of birth control method are you using? (Check appropriate)	☐	
☐		1. None	☐	
☐		2. Birth control pills	☐	
☐		3. IUD (Loop)	☐	
☐		4. Foam	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number _____

NO		YES	COMMENT(S)
☐	5. Diaphragm	☐	
☐	6. Condoms	☐	
☐	7. Tubes Tied	☐	
☐	8. Other: _____		
☐ f.	Do you have a discharge now?	☐	
☐ g.	When was your last Pap Smear?	☐	
	_____		
☐ h.	Ever had an abnormal Pap smear?	☐	
☐ i.	How many times have you been pregnant? _____		
☐	1. Full term _____	☐	
☐	2. Premature _____	☐	
☐	3. Miscarriages _____	☐	
☐	4. Abortions _____	☐	
☐	5. Are you pregnant now?	☐	
☐ j.	Do you examine you breasts regularly?	☐	
☐ k.	Ever found any lumps in your breasts?	☐	
☐ l.	Ever had discharge from your nipples?	☐	
☐ m.	Have you had the Measles, Mumps, and Rubella Vaccine (MMR) as an adult?	☐	
17.	***SKIN***		
☐	Tattoos, piercings, lesions, ulcers, tags, moles, insect bites, rashes, or infections?	☐	

I certify that the foregoing information supplied by me is true and complete to the best of my knowledge.

Date	Signature of Patient	Signature of Person Reviewing History

TENNESSEE DEPARTMENT OF CORRECTION

IMMUNIZATION / TB CONTROL RECORD - INMATE

Enter Institution.
INSTITUTION

NAME Enter Name. TDOC NUMBER Enter TDOC Number.

IMMUNIZATIONS

DATE	VACCINE	DOSE	SIGNATURE
Enter Date.	Enter Vaccine.	Dose.	
Enter Date.	Enter Vaccine.	Dose.	
Enter Date.	Enter Vaccine.	Dose.	
Enter Date.	Enter Vaccine.	Dose.	
Enter Date.	Enter Vaccine.	Dose.	

TUBERCULOSIS SCREENING AND SURVEILLANCE

INITIAL SCREENING:

Date IGRA Drawn	Date of Results	Reaction (Neg/Pos)	Chest X-Ray Date / Results		Preventive Treatment Started / Completed	
Enter IGRA Drawn Date.	Enter IGRA Drawn Date.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.

PERIODIC SCREENING: READ AFTER 48 – 72 HOURS IN MM

Tuberculin Test Date Antigen/Method/Initials		Date Read / Initials		Reaction in MM	Chest X-Ray Date / Results		Preventive Treatment Started / Completed	
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.

TUBERCULOSIS SURVEILLANCE: FILL IN IF POSITIVE PPD OR IF DISEASE OCCURS

Bacteriologic Examination Date / Results		Diagnosis Date / Diagnosis		Treatment Started / Completed	
Enter Date.	Enter Results.	Enter Date.	Enter Diagnosis.	Enter Started Date.	Enter Completed Date.
Enter Date.	Enter Results.	Enter Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Date.	Enter Results.	Enter Date.	Enter Diagnosis.	Enter Started Date.	Enter Completed Date.
Enter Date.	Enter Results.	Enter Date.	Enter Diagnosis.	Enter Started Date.	Enter Completed Date.

☐ Report Complete

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES

REFUSAL OF MEDICAL SERVICES

INSTITUTION _____

Date _____ 20 _____ Time _____ AM/PM

This is to certify that I _____, _____
(Inmate's Name) (TDOC Number)
have been advised that I have been scheduled for the following medical services and/or have been advised to have the following evaluations, treatment, or surgical/other procedures:

_____

_____

_____

I am refusing the above listed medical services against the advice of the attending physician and/or the Health Services staff. I acknowledge that I have been informed of the risks involved by my refusal and hereby release the State of Tennessee, Department of Correction, and their employees from all responsibility for any ill effects which may be experienced as a result of this refusal. I also acknowledge this medical service may not be made readily available to me in the future unless an attending physician certifies my medical problem as a medical emergency.

Signed: _____ _____ _____
(Inmate) (TDOC number) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

The above information has been read and explained to,

_____ _____ but has refused to sign
(Inmate's Name) (TDOC number)
the form.

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)