# Tetanus and Diphtheria (Td) Vaccine Protocol

Vaccine Protocol for children less than age 7 years with contraindication to pertussis-containing vaccine

**Document reviewed and updated:** **March 26, 2024**

## Condition for protocol

To reduce incidence of morbidity and mortality of diphtheria and tetanus disease.

## Policy of protocol

The nurse will implement this protocol for Td vaccination in children less than age 7 years for children <7 years old who have a contraindication to pertussis-containing vaccine.

## Condition-specific criteria and prescribed actions

**Delete this entire paragraph before printing/signing protocol.**

[Instructions for persons adopting these protocols: The table below lists indication, contraindication, and precaution criteria and suggested prescribed actions that are necessary to implement the vaccine protocol. The prescribed actions include examples shown in brackets but may not suit your institution’s clinical situation and may not include all possible actions. A licensed prescriber must review the criteria and actions and determine the appropriate prescribing action.]

Indications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Child is <7 years old and has a history of encephalopathy not attributable to another identifiable cause that occurred within 7 days of administration of a previous dose of pertussis-containing vaccine. | Proceed to vaccinate if meets remaining Td criteria and has been evaluated by a health care provider for diagnosis and treatment of encephalopathy attributable to a dose of pertussis-containing vaccine. Healthcare providers can request a consultation from CDC’s Clinical Immunization Safety Assessment Service: [CDC: Clinical Immunization Safety Assessment (CISA) Project (www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/cisa/index.html)](https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/cisa/index.html) |
| Child is less than age 6 weeks. | Do not give. [Reschedule vaccination when child meets age criteria.] |
| Child is 7 years or older. | Follow protocol for Td/Tdap administration for >7 years old. |
| Person is more than 1 month behind routine schedule. | Follow protocol for catch-up vaccination for Td. |

Contraindications

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Person had a systemic allergic reaction (anaphylaxis) to a previous dose of DTaP/DT/Td vaccine. | Do not vaccinate; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Person has a systemic allergy to a component of DTaP/DT/Td vaccine. | Do not vaccinate; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Precautions

|  |  |
| --- | --- |
| Criteria | Prescribed action |
| Person is currently on antibiotic therapy. | Proceed to vaccinate. |
| Person has a mild illness defined as temperature less than \_\_\_\_°F/°C with symptoms such as: {to be determined by medical prescriber} | Proceed to vaccinate. |
| Person has a moderate to severe illness defined as temperature \_\_\_\_°F/°C or higher with symptoms such as: {to be determined by medical prescriber} | Defer vaccination and {to be determined by medical prescriber} |
| Person experienced an arthus-type hypersensitivity reaction to a previous dose of DTaP/DT/Td. | [Do not give additional tetanus and diphtheria-containing vaccine for a minimum of 10 years from the last dose.] |

## Prescription

### Routine vaccination

Give Td 0.5 ml, IM at ages 2 months, 4 months, 6 months, 15-18 months\* and 4-6 years.

\*A child may receive his/her fourth dose of Td as early as age 12 months, as long as it will be at least 6 months between doses three and four and the assessor has a concern that the child will not return at 15 months of age.

### Catch-up schedule

**Minimum interval between doses**:

* Dose one to dose two: 4 weeks
* Dose two to dose three: 4 weeks
* Dose three to dose four: 6 months
* Dose four to dose five: 6 months
* Dose five is not necessary if dose four was administered at age 4 years or older and at least 6 months after dose three.

## Medical emergency or anaphylaxis

Follow pre-established agency protocol for anaphylaxis.

## Question or concerns

**Insert overseeing medical consultant’s information below and delete this sentence before printing/signing.**

In the event of questions or concerns call (insert name) at (insert phone number).

**This protocol shall remain in effect until rescinded.**

Name of prescriber (please print):

Prescriber signature:

Date: