

MCN for Neonatology West of Scotland Neonatal Guideline



Immunisation Guideline for Neonates

This document is applicable to all medical, midwifery and nursing staff caring for the infant in hospital or community. The guideline should be used with reference to the relevant pharmacy monographs. For further guidance on Immunisation staff should refer to the online "Green Book".

Further guidance on the use of immunoglobulin is available here: [Clinical Guidelines – NPPEAG](#)

Notes

Consent: Signed consent should be sought at the start of the vaccination schedule and retained in the notes. It should be clear in the documentation of consent which immunisations are included in the schedule. If the infant remains in hospital when subsequent doses are due the parents should be informed that the dose is to be given however additional documentation of consent is unnecessary.

Injection technique With the exception of BCG, immunisations should be given in either the anterolateral thigh or the deltoid muscle using a 23G or 25G needle. It must be ensured that the injection is intramuscular (IM) i.e. use a needle of sufficient length inserted to a sufficient depth to reach the muscle. Do **not** bunch the skin up at the injection site. The buttock should only be used for large volume injections such as Palivizumab (Synagis) or immunoglobulin. When the buttock is used the injection site must be in the upper, outer quadrant.

The Green Book – Chapter 4 – Immunisation techniques

Some infants with bleeding disorders should receive immunisations by deep subcutaneous injection-see WoS Neonatal Haematology Guideline which defines which infants should not receive IM injections.

Post immunisation apnoea

Preterm babies with a history of apnoea or prolonged oxygen therapy should be monitored for apnoeas and desaturations for at least 24 hours after the first vaccine dose as there are reports of a recurrence of apnoeas after the initial dose.

Immunisation and surgery

Surgery is not, in itself, a contraindication to immunisation. If surgery is planned, it is prudent to avoid vaccination in the few days leading up to the procedure, as minor reactions to vaccination, such as fever, may lead to cancellation of the surgery. Vaccination may be given as soon as the patient has recovered from the immediate effects of anaesthesia and surgery. *NB – please see the section on Rotavirus immunisation for specific cautions following GI surgery.*

Live vaccines in infants born to mothers who have received biologic immunosuppressive therapy during pregnancy or while breastfeeding

Whether an infant can receive a live vaccine will depend on the drug involved and how long it was continued during pregnancy. A plan should be made with an appropriate specialist and the mother during pregnancy.

The British Society of Rheumatology and the British society of gastroenterology provide the following guidance (which may conflict with manufacturers' and national guidance):

[BSR stands by pregnancy guideline recommendations on the safety of HCQ Antenatal Care for IBD Patients | BSG Guidelines & Standards](#)

A delay for immunisation until 6 months of age is advised for most biologic immunosuppressive agents (Green Book), although most infants can be considered for Rotavirus vaccine. Manufacturers' of Infliximab advise avoiding live vaccines until 12 months of age in infants exposed in utero or through breastfeeding unless infant levels are undetectable. Consideration should be given to measuring infant levels at 6 months of age if there is high need for a live vaccine e.g. BCG before 12 months of age.

For infants exposed to immunosuppressive biological therapy in utero or through breastfeeding, risk vs benefit of administering a live vaccine should be determined on an individual patient basis. Discuss with pharmacy, an Infection specialist or the Public Health team. See also Rotavirus and BCG sections below.

Deferral of Vaccination following Immunoglobulin Treatment

Immunoglobulins and other blood products may interfere with the immune response to many live vaccine viruses. Live viral vaccines should therefore be given at least three weeks before or three months after an injection of immunoglobulin.

- Deferral of BCG vaccine is not required because immunoglobulins are unlikely to interfere with the cellular response to this vaccine. Therefore, babies who have received hepatitis B immunoglobulin and are eligible for BCG vaccination can receive the vaccine without any deferral.
- Where rapid protection is required, vaccination should proceed but may require repetition at a later stage to ensure longer term protection.

Routine Childhood Immunisation Schedule – to 13 months

When to immunise	What is given	Vaccine and how it is given
8 weeks old	Diphtheria, tetanus, pertussis, polio, <i>Haemophilus influenzae</i> type b, and Hepatitis B (DTaP/IPV/Hib/HepB)	One injection (Infanrix hexa ®)
	Meningitis B	One injection (Bexsero ®)
	Rotavirus	One oral dose (Rotarix ®)
12 weeks old	Diphtheria, tetanus, pertussis, polio, <i>Haemophilus influenzae</i> type b, and Hepatitis B (DTaP/IPV/Hib/HepB)	One injection (Infanrix hexa ®)
	Meningitis B	One injection (Bexsero ®)
	Rotavirus	One oral dose (Rotarix ®)
16 weeks old	Diphtheria, tetanus, pertussis, polio, <i>Haemophilus influenzae</i> type b, and Hepatitis B (DTaP/IPV/Hib/HepB)	One injection (Infanrix hexa ®)
	Pneumococcal (PCV)*	One injection (Prevenar 13 ®)
12 - 13 months (single visit)	Measles, mumps and rubella (MMR)	One injection (Priorix ® or MMRVaxPRO ®)
	Pneumococcal (PCV)	One injection (Prevenar 13 ®)
	Meningitis B	One injection (Bexsero ®)

*babies with asplenia, splenic dysfunction, complement disorder or who are severely immunocompromised will require additional doses of Pneumococcal (PCV)-see Green book for full details

Primary immunisation

- **DTaP/IPV/Hib/HepB (Infanrix hexa ®)**
- **Pneumococcal conjugate vaccine (Prevenar 13 ®)**
- **Meningitis B vaccine (Bexsero ®)**

Schedule –

- Three doses of DTaP/IPV/Hib/Hep B vaccine at 8, 12 and 16 weeks of age
- One dose of Pneumococcal vaccine* at 16 weeks of age
- Two doses of Meningitis B vaccine at 8 weeks and 12 weeks of age

Preterm babies follow the same protocol with no correction for their prematurity.

Meningitis B vaccine should be administered into the left thigh by preference. Other vaccines given at the same time should be administered into different limbs for optimal immune response (or at least 2.5cm apart if the same limb **must** be used).

* Only the conjugate vaccine **Prevenar 13 ®** should be used, as the pneumococcal polysaccharide vaccine (Pneumovax) is not suitable for children under the age of two. If the infant remains at high risk for pneumococcal disease beyond 2 years of age they should receive the 23-valent polysaccharide pneumococcal vaccine (Pneumovax). Refer to the "Green Book" for at-risk conditions

Contraindications

- Contraindications for preterm babies are as for term babies – refer to the "Green book".

Caution in Very Premature Infants

- Very premature infants (born $\leq$ 28 weeks of gestation) who are in hospital should have respiratory monitoring for 48-72 hrs following their first immunisation, particularly those with a previous history of respiratory immaturity. If the child has apnoea, bradycardia or desaturations after the first immunisation, the second immunisation should also be given in hospital, with respiratory monitoring for 48-72 hrs post-dose

Paracetamol for febrile reactions

- Fever is a common reaction following vaccination, particularly following vaccination with Bexsero for Meningitis B. The JCVI recommends the administration of three doses of Paracetamol following vaccination. One dose should be given at the time of administration, and two further doses at 6 hourly intervals (refer to the paracetamol monograph for doses).
- Recent systematic review (Das et al 2014) has concluded that previous concerns regarding the effect of anti-pyretics on the immunogenicity of childhood vaccines are no longer felt to be clinically significant. In order to avoid confusion, this guideline will recommend prophylactic paracetamol is given with each of the routine vaccinations given to inpatients in the neonatal unit.

Documentation

A record of the vaccinations given along with the batch numbers and the site of each injection should be entered in the infant's notes. The same information should be reported to SIRS (Scottish Immunisation Recall System) either by using an 'unscheduled attendance form' or other local proforma

Local arrangements for reporting vaccination to SIRS

NHS GGC: A copy of the inpatient prescription form(Appendix) should be sent by email to public health

NHSL: A copy of the inpatient prescription form should be posted to public health(address on prescription form)

Patient information

Protect your child against serious diseases booklet (N.B website also has easy to read versions and other language versions):

[Protect your child against serious diseases - Publications - Public Health Scotland](#)

Vaccination consent form – See Appendix

Rotavirus vaccine - (Rotarix ®)

Schedule

Two doses of Rotarix ® oral vaccine normally given at the time of the first and second primary vaccinations, at 8 and 12 weeks of age with no correction for prematurity.

If there are any contraindications to rotavirus vaccination at the normal vaccination age the doses may be given at a later date. However, due to a small risk of intussusception when the rotavirus vaccination is administered at later ages the vaccine doses must be given by the following **chronological** ages.

- The first dose should be given ideally by 12 weeks of age and **must not** be given if the baby is 15 weeks of age or older (more than 14 weeks and 6 days)
- The second dose should be given ideally by 16 weeks of age with a minimum interval of 4 weeks and **must not** be given if the baby is 24 weeks of age or older (more than 23 weeks and 6 days). If the course is interrupted, it should be resumed, **but not repeated**, in line with the restrictions on timings above.
- The vaccine can be given at the same time as any other vaccination including BCG

Administration

Rotarix is an oral vaccine and should be administered using the applicator provided. The full dose (1.5 ml) should be given into the mouth towards the cheek. If the dose is spat out or vomited an additional dose may be used immediately after the failed dose.

Contraindications

- Hypersensitivity to the active substance or to any of the excipients listed in SPC.
- Hypersensitivity after previous administration of rotavirus vaccines.
- Rotarix is a live vaccine and is contraindicated in babies with severe combined immune deficiency (SCID). In other immune deficient states it is advised that the benefits of protection outweigh the risks and the vaccine should be offered (*including babies born to HIV positive mothers, before the baby's HIV status is known and babies who have received multiple courses of steroids*).
- Infants with a history of intussusception or who have a malformation of the GI tract which would predispose them to intussusceptions. (**See cautions below**).
- Infants with the following inherited disorders - fructose intolerance, glucose- galactose malabsorption or sucrase-isomaltase insufficiency.
- Infants who are 24 weeks and 0 days or older

Cautions

- Vaccination should be delayed in following circumstances
 - infants with a febrile illness or who have vomiting or diarrhoea of any cause
 - Patients having undergone recent intestinal surgery should be discussed with the surgical team on an individual case basis
 - Infants who have a confirmed diagnosis of NEC in the preceding 2-3 weeks
- Where a mother has received immunosuppressant biological agents during pregnancy, the infant may receive Rotavirus vaccine following a risk vs benefit discussion. (see also Live Vaccine section above)

NB - Where vaccination is delayed the schedule should be resumed within the timescales outlined above.

- Infants born at ≤ 28 weeks gestation should be monitored for apnoea for 48 - 72 hours after administration of the first dose. If apnoea is noted after the first dose then the babies should be monitored similarly after the second dose
- Rotarix is a live vaccine, although highly attenuated. The vaccine virus is excreted in the faeces for 2-3 weeks after administration. If transmitted to an immuno-compromised contact the virus could result in minor gastrointestinal symptoms. Normal hygiene precautions should be used to prevent transmission
- Intussusception has been reported in 2:100,000 cases.

Patient information Protect your child against serious diseases booklet (N.B website also has easy to read versions and other language versions):

[Protect your child against serious diseases - Publications - Public Health Scotland](#)

Hepatitis B vaccine (Engerix B ®, HBVaxPRO ®)

Indications for accelerated Hepatitis B vaccination

- All babies whose mothers have a history of past or present hepatitis B. Some will also require Hepatitis B immunoglobulin
see next section for indications for Hepatitis B immunoglobulin.

NB babies born to a mother who is negative for hepatitis B but who will subsequently be living with another individual who is positive for Hepatitis B should get a single dose of monovalent Hepatitis B vaccine at birth but should otherwise follow the routine childhood vaccination schedule

Monovalent Preparation - Only Engerix B (0.5ml) to be used.

Schedule – Two doses of monovalent Hepatitis B vaccine should be given, at birth and at 4 weeks of age. The first dose is to be given as soon as possible after birth (within 24 hrs of delivery at the latest). Subsequent to this, infants born on, or after, the 1st July 2024 should be offered Infanrix Hexa vaccine according to the normal childhood schedule outlined above. This will involve 3 doses of the Hexavalent vaccination at 8, 12 and 16 weeks of age, with an additional 4th dose now administered at 18 months of age.

Preterm babies follow the same schedules with no correction for their prematurity.

For infants born to mothers infected with Hepatitis B, serology is required between 12 and 18 months of age to determine whether vaccination has successfully prevented infection with Hepatitis B.

Hepatitis B in the Immunisation schedule for routine childhood and selective neonatal hepatitis B programmes following the introduction of the Infanrix hexa®

Age	Routine Childhood		Babies born to Hepatitis B negative mothers but who will be living in a household with another infected person		Babies Born to mothers infected with Hepatitis B	
Birth	No		Yes	Monovalent Hepatitis B vaccine	Yes	Monovalent Hepatitis B vaccine +/- Immunoglobulin
4 weeks	No		No		Yes	Monovalent Hepatitis B
8 weeks	Yes	Infanrix Hexa	Yes	Infanrix Hexa	Yes	Infanrix Hexa
12 weeks	Yes	Infanrix Hexa	Yes	Infanrix Hexa	Yes	Infanrix Hexa
16 weeks	Yes	Infanrix Hexa	Yes	Infanrix Hexa	Yes	Infanrix Hexa
By 18 months	No		No		Yes	Infanrix Hexa+ Test for HBsAg

Local arrangements for serology – GG&C

This is arranged by the GP, with a reminder to them from public health **if the postnatal notification form** (see appendix) **has been completed and returned.**

Reporting - Women who are surface antigen positive on antenatal screening will have been reported to Public Health prior to delivery who will in turn inform the Obstetricians. All immunised infants, low or high risk, must be reported to the Community Screening Department to ensure adequate follow-up. Notification forms (*see appendix*) should be scanned and emailed to the Community Screening Department, and the original stored in the baby's notes, as soon as possible after vaccination/immunoglobulin administration. Please note that where there is uncertainty about a baby's final discharge address or carer (i.e. when there is consideration of foster care etc.) at the time of vaccination then it is better to send the form with the current maternal details in place to Public Health. Delaying sending the form until such details are complete can cause delays and confusion- the CHI number allows effective tracking of the baby through public health systems.

Antenatal testing process.

Please refer to the obstetric guidelines page for full details.

In summary hepatitis B testing is offered as part of routine booking bloods to all pregnant women. In the event of a positive result the Regional Virus Laboratory will inform the patient's obstetrician and a named link obstetrician by letter. This letter will give recommendations for vaccination +/- immunoglobulin administration depending on the maternal serology (predominantly based on e antigen and antibody status at this point). The named obstetrician will also record these recommendations on the neonatal alert section of the maternal notes.

At 26 weeks gestation all of those that had tested positive on booking bloods will have further bloods taken by their obstetrician for HBV DNA levels. **Following this the recommendation for neonatal treatment of the baby may change** (if the HBV DNA level is $\geq 200,000$ IU/mL ($\geq \log 5.3$) but initial serology was anti-HBe positive). The named link obstetrician will amend the initial virology letter and the neonatal alert sheet with this information ensuring that up to date and accurate information is available to the neonatal team at delivery.

Notes - In viral infections the presence of virus indicates ongoing infection and the detection of specific antibody indicates previous infection. Following hepatitis B infection, 90% of individuals clear the virus, become immune and are not infectious to others. These patients do not have detectable circulating virus (hepatitis B surface antigen (HBsAg) negative) but have antibody against hepatitis B core antigen (anti HB core positive). Note that immunisation stimulates antibody against HBsAg (anti HBs) but not against HBcore antigen (anti HB core negative). A small minority of those infected by hepatitis B virus remain carriers of the virus and are HBsAg positive. If the hepatitis B e-antigen (HBe antigen) is positive, this means that the patient has viral protein associated with a high rate of transmission. Babies of women who are infectious carriers may be infected at delivery (or rarely during pregnancy). Perinatal infection has a much higher risk of carrier status, more common among people born in endemic areas such as South East Asia. Hepatitis B virus can also be transmitted through intravenous drug use or sexual intercourse. These transmission routes are less likely to result in carrier status. Babies of non-infectious women are not at risk of vertical transmission but other members of the family may be carriers and the mother's immunity may indicate a high-risk environment in which the baby may be infected at a later date.

The risk of perinatal transmission can be reduced by administration of hepatitis B immunoglobulin (HBIG) at birth together with a course of active immunisation (HB vaccine). Environmental infection can be avoided by active immunisation commenced at birth, but in this situation, HBIG is not required. (See indications for Hep B Immunoglobulin – next section).

***See Scottish Neonatal Guideline for the management of infants born to mums with Hepatitis B** [Hepatitis-B-virus-Prevention-of-perinatal-transmission-Guideline-2024.pdf](#)

Hepatitis B immunoglobulin

Schedule

A single dose of 250 international units should be administered as soon as possible after birth to babies who are at high risk of perinatal transmission. The volume is variable dependent on the strength of each individual batch however the volume of this preparation will always be such that the dose must be split and injected into two separate sites.

Indications

Hepatitis B immunoglobulin is indicated in the following situations:-

- Mothers who are persistent carriers of hepatitis B surface antigen (HBsAg), where hepatitis e antigen (HBeAg) is detectable or its antibody (Anti-HBe) is not (see Notes).
 - Mothers who are HbsAg positive as a result of recent acute infection (see Notes).
 - HBsAg positive, where e-markers have not been determined (often late booking mothers)
 - Mothers who are HbsAg positive and the baby's birth weight is 1500g or less regardless of e-antigen status of mother.
- e) Woman is HBsAg seropositive and known to have an HBV DNA level above 200,000 IU/mL ($\geq \log 5.3$)** in an antenatal sample (regardless of HBeAg and anti-HBe status)

Summary of indications for Hepatitis B Immunisation & Immunoglobulin

Hepatitis B status of mother	Baby should receive:-	
	Hepatitis B vaccine	HBIG
HBsAg positive and HBeAg positive	yes	yes
HBsAg positive, HBeAg negative and anti-HBe negative	yes	yes
Acute hepatitis B during pregnancy	yes	yes
HBsAg positive, anti-HBe positive	yes	no
HBsAg positive and a baby birthweight of 1500g or less	yes	yes
Woman is HBsAg seropositive and known to have an HBV DNA level above 200,000 IU/mL ($\geq \log 5.3$)** in an antenatal sample (regardless of HBeAg and anti-HBe status)	yes	yes

** Note, the 'Green Book' (Immunisation against Infectious Disease, Public Health England, 2013) states 'equal or above 1×10^6 IUs/ml'.

Local arrangements for supply – All immunoglobulin preparations are now supplied by Pharmacy. Local arrangements for availability out-of-hours are detailed below:-

- PRM** – 2 vials of Hepatitis B Immunoglobulin are kept in the neonatal unit. 2 further vials are available in A&E and another 2 in the emergency drug cupboard in the GRI. The latter may be accessed by paging the hospital coordinator via switchboard.
- RHC** - Hepatitis B immunoglobulin is available in the neonatal unit
- RAH** - Hepatitis B immunoglobulin is available via the EDC pharmacist or from A&E
- UHW-Hepatitis B immunoglobulin is available via Labs**

References

[Guidance on the use of Hepatitis B immunoglobulin](#) – UK Health Security Agency

Scottish Neonatal Guideline for the management of infants born to mums with Hepatitis B [Hepatitis-B-virus-Prevention-of-perinatal-transmission-Guideline-2024.pdf](#)

[Green Book chapter 18 Hepatitis B](#)

Management of Babies Born to Mums With Chickenpox

Schedule

A single intravenous infusion dose of 50 units/kg of Varitect®CP given as soon as possible and at least within 96 hours

N.B. Intramuscular Varicella Zoster Immunoglobulin (VZIG) is no longer available

Indications for Varitect®CP

- Infants whose mothers develop chickenpox (but not herpes zoster) in the period 7 days before to 7 days after delivery. It can be given without antibody testing of the infant or mother. IV aciclovir must also be given for a minimum of 48 hours (with treatment initiated as soon as possible after birth). Treatment should be continued until day 21 post-delivery, but can be switched to oral aciclovir after 48 hours if preferred. Where there will be a delay in obtaining Varitect®CP within 96 hours, intravenous immunoglobulin (IVIG) should be given instead (see IVIG(PEP) monograph)
- All other at-risk neonatal contacts who have confirmed exposure to chickenpox should be given oral aciclovir starting 7 days after exposure, instead of VZIG (see the *WoS Neonatal Oral Aciclovir Monograph* for detailed guidance). Where aciclovir is contra-indicated, intravenous immunoglobulin (IVIG) should be given instead.

Mothers who have a positive history of chickenpox may be assumed to be VZ antibody positive. In the absence of a definite history, maternal antibody status can normally be established quickly by liaising with the virus lab.

Exposure to chickenpox can be said to have occurred where there has been direct, indoor contact with someone who has active chickenpox (or who develops vesicles within a few days of such exposure). Sufficient exposure to place a susceptible individual at risk may be brief if the exposure was face to face e.g. someone cuddling, feeding or changing the baby. If the contact is not face to face, sufficient exposure will only occur after a more prolonged period (> 15 mins). Where a contact has shared a hospital room with a case of chickenpox, but where there has been no direct contact, much longer periods are required to give sufficient exposure.

N.B. The baby should be isolated for 21 days and the contact excluded from the unit until all lesions have crusted over. If the contact is a parent they may attend the unit but remain in strict isolation with their baby for this period. (This is not necessary if the parent has shingles in an area of the body which is completely covered with clothing). The baby should be cared for only by members of staff who are immune to chickenpox.

Local arrangements for supply – A stock of varicella zoster immunoglobulin for Scotland is held at Queen Elizabeth University Hospital (QEUH) Glasgow. For supply within working hours please contact the ward pharmacist. Out of hours supply will be via the QEUH/RHC on call pharmacist

References UK Health Security Agency Guidelines on post exposure prophylaxis(PEP) for varicella or shingles (February 2025)

-UK Health Security Agency

Patient information

[Chicken Pox in Pregnancy: What you need to know](#) - RCOG

BCG vaccine

Please carefully read the monograph if you are unfamiliar with the use of this preparation

[Protect your baby against tuberculosis \(TB\) - Publications - Public Health Scotland](#)

Schedule

1. A single dose, administered in the neonatal period or at the time of the first vaccinations at 8 weeks, should be offered to high risk groups as detailed below.
2. Infants born to mothers with sputum positive TB should be treated prophylactically for three months. Following this they should have a Mantoux test. See . [The Mantoux Test- Administering, reading and interpreting a tuberculin skin test](#). If the Mantoux test is negative they should receive their BCG vaccination. It is **not** necessary to use isoniazid resistant BCG. Prophylactic treatment will include Isoniazid with or without the addition of Rifampicin – the respiratory team at RHC should be consulted. All babies should receive Pyridoxine whilst on Isoniazid prophylaxis.
3. Infants born to mothers who have completed a course of TB therapy during pregnancy and are considered cured, or where they have positive skin tests without evidence of disease may be given BCG at birth **IF** household screening has been carried out. If the rest of the household has not been screened, then the baby should receive prophylaxis as above until there is no chance of contact with potentially contagious individuals. The baby should then have a Mantoux test at 6 weeks and receive BCG vaccine at this time if negative.

Indications

- Infants from families where the parents or grandparents were born in a 'high risk' country – *i.e. a country with a TB incidence of more than 40 cases / 100,000 population*
 - '**High Risk' Country list** - derived from [UK Health Security Agency](#)
 - OR – visit the WHO site [TB incidence \(who.int\)](#) for up to date information
- Any child likely to spend more than 3 months in the above countries in the next 5 years
- Where there is a current or past history (within previous 5 years) of TB in the household or in a frequent visitor e.g. grandparents

Infants born in, or moving to, an area of the UK where the incidence of TB is more than 40 cases /100,000 population - [TB incidence and epidemiology in England, 2021 - GOV.UK \(www.gov.uk\)](#)

N.B. - No NHS boards in Scotland fall into this category

Contraindications

Babies born to mothers who are HIV +ve should not be given BCG vaccination until the baby has tested -ve for evidence of HIV particles at 3 months. All mothers of infants eligible for BCG should be informed that HIV is a contraindication to BCG vaccination. If they believe they may be at risk of HIV and have not been tested in pregnancy (HIV screening is now offered to all pregnant women) then they should be offered screening before their baby is immunised.

BCG should also be delayed if the infant has recently been treated with systemic corticosteroids

BCG vaccination should not be given until 6 months of age if the mother has had treatment with immunosuppressive biologic agent or 12months of age if mother on Infliximab during pregnancy or while breastfeeding (unless infant infliximab levels are undetectable) (see Live Vaccine section above)

Administration

The dose must be given **intradermally**. It is given at the insertion of the Deltoid muscle in the Left upper arm. **Do not give if you are unfamiliar with the technique of intradermal injection. N.B post - administration skin testing is unnecessary**

Documentation

The administration of the vaccine should be recorded in the notes along with the batch number. A public health notification slip should be completed (*see appendix*) and all three parts returned to public health. N.B. please include the GP details and the name that the child will be known as after discharge.

Local arrangements for administration of the BCG vaccine

PRM - A BCG clinic run by the public health team is held 2 weekly on a Tuesday afternoon. If parents are happy for their child to be given BCG, a referral should be completed online and parents told to expect to receive an appointment by post within a couple of weeks. The online form is available in the Paeds share folder (in the BCG subfolder - please use the latest version), and should be emailed to the link provided in the form.

If vaccination is given prior to discharge, to avoid the possibility of repeat immunisation, the baby's details must be recorded on the Spreadsheet in the Paeds folder ("babies given BCG") and a notification form sent to public health. Please give the form to the paediatric secretaries. Any existing BCG clinic appointment should be cancelled.

RHC - Babies identified on the PNW or in SCBU/NICU prior to discharge as at increased risk of TB are referred to outpatient Public Health Medicine clinics for BCG immunisation. Patient details must be given to neonatal secretaries by the doctor, ANNP or midwife performing the neonatal examination. A standardised letter will be sent to Public Health, a copy of which will be filed in the patient's notes

RAH - BCG immunisation is given as an outpatient by referral - see local policy.

UHW-babies identified on the PNW or in SCBU/NICU prior to discharge as at increased risk of TB have NIPE risk form ticked for BCG vaccination. This is picked up by Health Visitor Team who organise community administration of BCG and liaise directly with Public Health

[NICE TB Guidelines](#)

Palivizumab - Synagis ®

JCVI recommendations for treatment with Synagis ® are as follows

- 1. Preterm infants with CLD** (defined as oxygen dependency or respiratory support until at least 36 weeks corrected gestational age) at the chronological ages at the start of the RSV season and gestational ages at birth covered within the shaded area in Table 1.

Table 1	Gestational Age at birth						
Chronological age	≤24	24-26	26-28	28-30	30-32	32-34	≥35
1.0 to <1.5 months							
1.5-3 months							
3-6 months							
6-9 months							
>9 months							

NB – Infants of any gestation who have chronic respiratory disease requiring O2 therapy or long-term ventilation, at the start of the RSV season, are also eligible

- 2. Pre-term infants with haemodynamically significant, acyanotic CHD**
OR - infants with cyanotic or acyanotic CHD plus significant comorbidities at the chronological ages at the start of the RSV season and gestational ages covered within the shaded area in Table 2.

Table 2	Gestational Age at birth						
Chronological age	≤24	24-26	26-28	28-30	30-32	32-34	≥35
<1.5 months							
1.5-3 months							
3-6 months							
6-9 months							

- 3. Infants with Severe Combined Immunodeficiency are also eligible.**

Where clinical judgement of other individual patient circumstances strongly suggests that prophylaxis would prevent serious RSV infection in infants who are at particular risk of complications from RSV, use of Synagis® could be considered during the RSV season.

Dosage and administration

Synagis® should be given as a maximum of five doses (15mg/kg/dose) given one month apart from the beginning of the RSV season (beginning of calendar week 40 i.e. beginning of October). However, where the course of treatment begins later in the RSV season (e.g. where infants are born within the RSV season) up to five doses should be given one month apart until the end of calendar week 8 (i.e. the end of February). As the risk of acquiring RSV infection while in the neonatal unit is extremely low, infants in neonatal units who are in the appropriate risk groups should only begin Synagis® treatment 24 to 48 hours before being discharged from hospital. An exception is twins; where one twin is ready for discharge, but the other remains in the NNU, consideration should be given to immunising the hospitalised twin to ensure that follow up doses for both twins will be due simultaneously. Those infants that have begun a course of Synagis® treatment but are subsequently hospitalised should continue to receive Synagis® whilst they remain in hospital.

Local Arrangements for administration of Synagis – GG&C

PRM, RHC - In order to coordinate administration, and minimise costs (by sharing partially used vials between multiple patients), all patients in Glasgow receive Synagis at a joint clinic in the Children's hospital. Names should be forwarded from each unit to a local coordinator who will arrange appointments – this individual's details will be circulated ahead of the RSV season

RAH – In RAH the administration of Synagis is performed by the Community Children's Nurses at monthly clinics held in the PANDA centre

UHW-Synagis clinics are coordinated by Pharmacy and the Community Liaison Team. -Monthly clinics are held in the hospital Outpatient department.

Influenza A vaccine

[Child flu vaccine | NHS inform](#) - information from NHS immunisation information site

Schedule

Two doses of 0.25 ml at 4 weekly intervals, starting at 6 months. In subsequent seasons only a single dose will be required.

Indications

This vaccine should be recommended in their first winter season for all babies who received prolonged respiratory support or oxygen therapy. It may be recommended in subsequent winter seasons for those infants who had severe chronic lung disease. NB - If the patient is too young for influenza immunisation (< 6 months) then the GP may be asked to offer Influenza vaccination to any other members of the immediate family who do not otherwise qualify for vaccination.

Useful Links

[NHS Inform Immunisation resource](http://www.immunisationscotland.org.uk/index.aspx) (www.immunisationscotland.org.uk/index.aspx)
[The 'Green Book' online](#)

[Guidance on the use of Immunoglobulins](#)
[NICE TB Guidelines](#)

References

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Further update(VZIG section only) December 2024:

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Updated June 2025

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Document Name

WoS_Immunisation_Neonates

Start / Review Dates

Next review date; June 2028

Appendices follow for Local Documentation



Routine Vaccination Schedule for all babies

Age	Vaccine	Mode of Administration
8 weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b, and Hepatitis B	One injection (InfanrixHexa ®)
	Meningitis B	One injection (Bexsero ®)
	Rotavirus	One oral dose (Rotarix®)
12 weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b, and Hepatitis B	One injection (InfanrixHexa ®)
	Meningitis B	One injection (Bexsero ®)
	Rotavirus	One oral dose (Rotarix ®)
16 weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b, and Hepatitis B	One injection (InfanrixHexa ®)
	Pneumococcal	One injection (Prevenar 13®)

Additional vaccines or immunoglobulin therapies recommended for your baby

Age	Vaccine / Immunoglobulin	Administration

I have received the leaflet written by Immunisation Scotland

“What to expect after vaccination: Babies and Children up to 5 years”

Initial

I have received information about each of the additional vaccines / immunoglobulins listed above

Initial

I have had the chance to ask questions about the vaccines and have had these questions answered

Initial

I agree to my child receiving the immunisations listed above

Initial

If for any reason you do not wish your child to receive all of the immunisations in the standard schedule, please indicate those which you **do not** wish your child to receive

Initial

Baby's Name CHI Number

Name Relationship to baby: Signature:.....

Witness: Signature:..... Date:

Attach baby's addressograph here or handwrite if no labels available
Patient Name:
Unit Number:
CHI Number:
DOB:
Address:
Postcode:

GP Address:
Postcode:

IN-PATIENT PRESCRIPTION FORM

To be used in conjunction with the WoS Immunisation

WHEN TO IMMUNISE	IMMUNISATION	Vaccine Batch number & Expiry (write / attach label)	DATE DUE	PRESCRIBER SIGN & PRINT	ADMINISTERED BY (Double signature)	DATE GIVEN
8 weeks	Diphtheria, tetanus, pertussis, polio, <i>Haemophilus influenzae</i> type b, and Hepatitis B (DTaP/IPV/Hib/HepB)	Batch No: Expiry:				
	Meningitis B	Batch No: Expiry:				
	Rotavirus (oral drops)	Batch No: Expiry:				
12 weeks	Diphtheria, tetanus, pertussis, polio, <i>Haemophilus influenzae</i> type b, and Hepatitis B (DTaP/IPV/Hib/HepB)	Batch No: Expiry:				
	Meningitis B	Batch No: Expiry:				
	Rotavirus (oral drops)	Batch No: Expiry:				
16 weeks	Diphtheria, tetanus, pertussis, polio, <i>Haemophilus influenzae</i> type b, and Hepatitis B (DTaP/IPV/Hib/HepB)	Batch No: Expiry:				
	Pneumococcal (PCV)	Batch No: Expiry:				

Guideline for Neonates

Preterm babies follow the same protocol with no correction for prematurity. Other vaccines given at the same time should be administered into a different limb (or min 2.5cm apart if the same limb **must** be used).

EACH TIME A PATIENT RECEIVES IMMUNISATIONS A COPY OF THIS SHEET SHOULD BE EMAILED TO

ChildHealth.Screening@ggc.scot.nhs.uk OR post to

Screening Dept, Templeton Business Centre, 3rd floor, Building 2, 62 Templeton Street, Glasgow, G40 1DA

Tel No: 0141 277 7516

REMEMBER TO UPDATE BADGER EACH TIME A PATIENT RECEIVES IMMUNISATIONS

Updated by:	L. Williams and A. MacLaren	Date updated:	June 2025	Approved by:	GGC Neonatal Risk Management Group
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Prevention of Hepatitis B Transmission in Newborn Babies

To be completed for every baby when given 1st hepatitis B injection in hospital

Baby's detail

First Name(s):	Surname:
Baby to be registered as:	CHI:
Date of Birth:	Sex:
Address (where baby will reside):	
Mother's Name:	Mother's Date of Birth or CHI:
Is Mother the carer? Yes ☐ No ☐	
(If not, please complete name of carer and relationship to child)	
Name of carer:	Relationship to child:
GP's Name:	HV's Name: (if known)
GP's Address:	

Record of Vaccination and Immunoglobulin

Drug	Date	Batch Number
Immunoglobulin (if applicable)		
1st dose hepatitis B vaccine		
2nd dose hepatitis B vaccine		

Why was hepatitis B vaccine given to this baby?

	Please tick box
Mother is a chronic carrier of hepatitis B virus (HBV)	
Mother is NOT a chronic carrier of HBV but another household member IS a chronic carrier of HBV	

Name of hospital:	
Signature:	
Print Full Name:	Date:

* If identity of carer or discharge address is not known at the time of administration, do not delay sending the form. The baby will be tracked through their CHI number.

**Please complete form and attach to email within 24 hours of vaccine or immunoglobulin administration. Email to HepB.Screening@ggc.scot.nhs.uk
Enquiries to Julie Mullin – Screening Dept – 0141 277 7601**

BCG Vaccination reporting sheet

BCG Vaccination Record					 Greater Glasgow and Clyde	
Clinic	Govanhill	PRM	Woodside	Other		
Category	At Risk Baby	At Risk Child	Contact	Other		
Surname			Forename			
DOB/CHI					Sex	M ☐ F ☐
Address						
City			Postcode			
GP Details						
GP Name				Prac Code		
Address						
City			Postcode			
Mantoux Test 2TU/0.1mls PPD						
Mantoux Date						
Batch No				Exp Date		
Dose		mls		Date Read		
Result mm						
Signature						
Print Name						
BCG Vaccination						
BCG Date						
Batch No				Exp Date		
Diluent Batch No				Diluent Exp Date		
Dose		mls		Site		(R) arm/leg (L) arm/leg
Signature						
Print Name						

white copy = GP, blue copy = health visitor, yellow copy = PHPU Dalian House