ADMISSIONS PACKET

Student's Name: _____ **Campus:** _____

COMPLETION OF THE FOLLOWING ITEMS IS REQUIRED PRIOR TO PLACEMENT

LEGAL INFORMATION & CONSENTS:

_____ Student Profile Sheet *(Page 1)*

_____ Legal Status Change *(Page 2)*

_____ 30-Day Withdrawal Notification *(Page 3)*

_____ Consent to Diagnostic, Therapeutic & Emergency Procedures *(Page 4)*

_____ Behavioral Management Policy & Consent *(Page 5)*

_____ Access To & Release of Confidential Records Consent *(Page 6)*

_____ Consent to: Religious Services Use of Photographs Field Trips *(Page 7)*

_____ Health Sexuality Curriculum & Family Planning Consent *(Page 8)*

MEDICAL REQUIREMENTS & CONSENTS:

_____ Medical Insurance Coverage Information *(Page 9)*

_____ Please Provide a copy of student's Birth Certificate

_____ Please Provide a copy of student's Social Security Card

_____ Please Provide a copy of student's Valid Medical & Dental Insurance Cards *(front & back)*

_____ Certificate for IV-E Eligibility Form *(Page 10)*

_____ Consent to Continue Medications *(Page 11)*

_____ Hepatitis B Vaccine Consent & Vaccine Information Statement *(Page 12)*

_____ Varicella (Chickenpox) Virus Vaccine Consent & Vaccine Information Statement *(Page 14)*

_____ Diagnostic Testing for Hepatitis B and C *(Page 15)*

_____ HIV - Authorization for Diagnostic Testing *(Page 16)*

_____ Student Immunization Consent: Td, DPaT, MMR & Polio Vaccine Information Statement *(Page 18)*

_____ Pre-Placement Physical Exam, Page 1 of 2 – General Information, History, and Testing *(Page 20)*

_____ Pre-Placement Physical Exam, Page 2 of 2 – Physical Exam, TB Risk Statement or Test Results *(Page 21)*

_____ Free of Communicable & Infectious Disease Statement - *"Examining Physician Must Sign"* *(Page 21)*

_____ Dental Consent & Dental Insurance Information

_____ Hepatitis A Vaccine Consent & Vaccine Information Statement

_____ Meningococcal Vaccination: Consent or Proof of Vaccination & Vaccine Information Statement

_____ Gardasil (HPV) Vaccination Consent & Vaccine Information Statement *(Boys ages 11 & older & Girls)*

HILLCREST REQUIRES AT LEAST A 30 DAY SUPPLY* OF ALL MEDICATION(S) FROM ORDERING PHYSICIAN
****MAY BE A COMBINATION OF MEDICATION AND PRESCRIPTION***

_____ Hillcrest Educational Centers' Placement Agreement

_____ Funding Commitment *(written approval of placement and funding)*

_____ Interstate Compact Approval *(Out-Of-State Students ONLY)*

_____

EDUCATIONAL:

_____ IEP OR if Regular Ed need name of IDENTIFIED SCHOOL DISTRICT

_____ Written Confirmation from School District/LEA Accepting Programmatic Responsibility

_____ Functional Behavioral Analysis (if applicable)

_____ Behavioral Intervention Plan (if applicable)

OTHER INFORMATION:

_____ Psychological Evaluation

_____ Psychiatric Evaluation

_____ Rogers Order(s) – ***(Rogers Affidavit required for antipsychotic meds)***

_____ Guardianship

_____ Clothing / Personal Belongings List – *please review & ensure that child arrives with appropriate clothing*

Student Profile Sheet
(please print)

Name: _____ **Date of Admission:** _____

Date of Birth: _____ Social Security Number: _____

Gender: _____ Hair Color: _____ Height: _____ Hearing Aids: Yes / No

Race: _____ Eye Color: _____ Weight: _____ Glasses: Yes / No

Place of Birth: _____ Braces: Yes / No

Citizenship: _____

Primary Language: (Student) _____ (Family) _____

Self-Preservation Skills: _____

ie. The ability to egress in the event of a fire. _____

Legal Guardian: _____ Phone: _____

Referring Agency Contact: _____ Phone: _____

Funding Source(s): _____

Custody Status: _____

(If you are divorced and there is a custody agreement, please provide a copy of the relevant portion of the separation agreement regarding custody. Please also provide any other orders or agreements regarding custody.)

School District Contact: _____ Phone: _____

Family Information: Marital Status: *(please circle)* Married Single Divorced Separated Widowed

Parent's Name & Address: _____ Phone: _____

_____ Birthplace: _____

_____

_____

Parent's Name & Address: _____ Phone: _____

_____ Birthplace: _____

_____ Maiden Name: _____

Emergency Contact: _____ Phone: _____

Address: _____ Relationship: _____

_____

_____

Medical Information:

Medical Condition(s) Significant to Child's Well Being: _____

_____

Allergies: _____

Date of Most Recent Physical Exam: _____ Date of Most Recent Dental Exam: _____

Discharge Data To Be Completed By Hillcrest Educational Centers

Date of Discharge: _____ Location/Name of Program: _____

Name & Address of Responsible Person: _____

_____

_____

Relationship: _____ Phone: _____

Legal Status Change Notification

(Please Print)

Student's Full Name: _____

As _____ 's parent(s) or legal Guardian(s), I/we agree to notify Hillcrest Educational Centers, Inc. in the event this child's legal status changes. Possible changes include, but are not limited to, place of legal residence, guardianship, custody and emancipation.

_____ I/We agree to provide notification if the status changes.

Signature: _____

30 Day Withdrawal Notification

(Please Print)

Hillcrest Educational Centers, Inc. requires a thirty (30) day notice of any withdrawal unless circumstances warrant an emergency discharge.

Failure to provide proper notification will require agencies to pay the approved per diem rate for the remainder of the 30 days.

Student's Name: _____

Agency: _____

Name: _____ Title: _____

Signature: _____

Date: _____

Consent & Authorization to Diagnostic, Therapeutic & Emergency Procedures

I/We, _____ , hereby give permission to the nursing staff of Hillcrest Educational Centers, Inc. ("Hillcrest"), to have _____ diagnosed and treated, under the direction of the attending physician(s) for all medical, routine dental care up to and including extractions, neurological, orthopedic, and surgical conditions.

I/We authorize and give consent to the physicians, their assistants, and the facilities caring for Hillcrest Educational Center's residents to diagnose and treat _____ .

These facilities include, but are not limited to Berkshire Health Systems and Hillcrest Dental Care.

It is the policy of Hillcrest to notify parents/guardians prior to any procedure that is other than routine in order to obtain informed consent. As set forth below, it may not be possible to obtain informed consent in the case of an emergency.

I/We also give permission to have _____ treated in emergency situations by Hillcrest staff, nurses, or outside medical providers when I/we cannot be reached for verbal permission via the telephone. It is the policy of Hillcrest to notify parents as soon as practical following any emergency procedure.

Hillcrest Educational Centers is unable to provide braces/orthodontics for the children in its care. It is unlikely that a child would reside at Hillcrest for the entire duration of the orthodontic process. The treatment of braces requires that the process begin and end with the same orthodontist.

For children entering Hillcrest with braces the parent/ guardian must be responsible for the ongoing follow-up required, including transportation and the cost associated with appointments and transportation.

Student's Name: _____

Name of Parent/Guardian: _____

Home Phone: _____ Work Phone: _____

Parent/Guardian Signature: _____ Date: _____

Behavioral Management Policy

Hillcrest Educational Centers is committed to providing children and youth served with a safe, trauma informed environment to address their treatment needs by using appropriate and effective therapeutic techniques in the most positive and the least restrictive and aversive manner possible.

Restraint is only utilized in Hillcrest programs when a student's behavior is dangerous to him/herself or others. Restraint is used exclusively as a clinically justified intervention, employing clear and specific procedures, during urgent or emergency situations when there is an emergent or immediate need and when all other appropriate and less restrictive interventions have not been successful.

Immediate need is defined as those situations that place the student him/herself and/or others in danger of harm or injury.

Restraint is only used in Hillcrest programs when other interventions have not been successful.

Restraint is discontinued as soon as it is safe to do so, as determined by the student's behavior and demonstrated self-control.

Additionally a restraint will be discontinued immediately if the student has visible bleeding, fluid coming out of their ears, seizure activity, vomiting, breathing difficulty, fracture or dislocation, is in an unconscious or unresponsive state, or any other indication of a medical emergency. If at any time during restraint a student states that they cannot breathe, staff will immediately discontinue the restraint.

This policy and these procedures are consistent with, and meet or exceed, all associated regulations of the Massachusetts Department of Early Education and Care (DEEC) and the Massachusetts Department of Elementary and Secondary Education (DESE), as well as associated standards promulgated by the Joint Commission.

Prone Restraint Policy
Prone (face-down) Restraint shall not be used unless Hillcrest Educational Centers, on an individual child basis, obtains and maintains documentation in accordance with 606 CMR 3.07(7)(j)15 or in circumstances where the use of prone restraint is required in an emergency situation to prevent serious injury to the resident, or other residents/staff.

Additionally, the use of prone restraint is prohibited for use at Hillcrest Educational Centers at all sites. Prone restraints will only be approved for use if all of the following has occurred: consent has been obtained from the student's legal guardian and an executive director or other designated administrator, medical and psychological screenings have been completed by approved person(s) and there is clear documentation of such with a lack of contraindications for prone restraints. It is also required that there is documentation of the student having a history of causing harm to self, peers or staff and all other intervention approaches have been unsuccessful on a historical basis.

Chemical Restraint Policy
Hillcrest does not perform chemical restraints at the following programs: Autism Spectrum Disorders, Highpoint, the Intensive Treatment Unit or Hillcrest Academy. This included the administration of non-voluntary PRN's for any purpose. A variance from the Department of Early Education and Care may be obtained on an individual basis to administer a non-voluntary PRN **at the Intensive Treatment Unit only.**

Mechanical Restraints
Hillcrest Educational Centers prohibits the use of mechanical restraints.

BEHAVIORAL MANAGEMENT POLICY PARENT/GUARDIAN ACKNOWLEDGMENT

(Please Print)

Having read Hillcrest's Behavior Management policy, I/we understand that physical restraints may be employed with

as deemed necessary by Hillcrest Staff.

_____

(Student's Name)

I/We acknowledge receipt of this policy

_____ _____ _____

(Parent/Guardian Signature) (Date)
(Date)

Access To & Release Of Confidential Records

I/We, _____, the parent(s)/guardian(s)/custodial agency of _____ *(Student's Name),* hereby give my/our consent to Hillcrest Educational Centers, Inc. ("Hillcrest") to receive and review all records, documents, and other information concerning the education and treatment for _____.

This includes, without limitation, team evaluations, materials, medical records, progress summaries, and information from past placements. I/We also authorize all prior teachers, physicians, psychologists, therapists or other persons who have worked with my/our child to speak with Hillcrest employees regarding my child.

I/We understand that Hillcrest will consider this material confidential. Records will be released only to the following individuals or entities subject to applicable law:

1. The student.
2. The student's parents/guardians, if the student is under the age of 18.
3. The student's legal guardian(s) or other authorized representative, Hillcrest's staff, employees and consultants providing services to the students.
4. Persons authorized by licensing agencies (e.g., the Office for Child Care Services, the Department of Education, the Department of Social Services, the Department of Mental Health) which have the responsibility of monitoring the quality of services being provided to the student.
5. The student's attorney or an advocate who has been authorized by the student, a court, the student's guardian(s) or, if the student is under the age of 18, the student's parents/guardians.
6. In the event that the student is being transferred from Hillcrest to another facility, the facility to which the student is being transferred.
7. Facilities that are considering the student for admission, but only after verbal or written consent has been obtained from the appropriate parent or custodial agency.

I/We also understand that the release of or access to confidential records will include inspection of the records.

I/WE HAVE READ THE ABOVE FORM AND UNDERSTAND ALL OF ITS TERMS. I/WE HEREBY GIVE MY/OUR CONSENT TO HILLCREST EDUCATIONAL CENTERS, INC., TO RECEIVE, REVIEW, RELEASE AND PROVIDE ACCESS TO ALL RECORDS, DOCUMENTS AND INFORMATION AS SET FORTH IN THIS FORM.

Parent/Guardian/Custodial Agency: _____

(Parent/Guardian Signature)

Date: _____

PARENT/GUARDIAN CONSENT FORM

Religious Services: Attendance, Participation

_____ **I/We DO** give my permission for my child to attend/participate in the religious services at Hillcrest Educational Centers.

_____ **I/We DO NOT** give my permission for my child to take part in the religious services at the Hillcrest Educational Centers.

_____ _____

(Parent/Guardian Signature) (Date)

Use of: Photographs, Audio-Visual Films, Name

_____ **I/We DO** give my permission to take and publish photographs, sound recording and films of my child, and to identify my child's name in print for purposes of staff and parent training, orientation, observation, documentation and public relations.

_____ **I/We DO NOT** give my permission to take or publish photographs, sound recordings, or films of my child, or to identify my child's name in print.

_____ _____

(Parent/Guardian Signature) (Date)

Athletics, Field Trips & Off Campus Trips *(Please Print)*

I/We, _____, the parent(s)/guardian(s)/custodial agency of _____ *(Student's Name),* understand that field trips frequently occur at Hillcrest Educational Centers, Inc. ["Hillcrest"] as part of the general educational and treatment program. For example, students may go bowling, swimming, skiing, participate in the NYPUM motorbike program or roller-skating, or may visit museums, the library, the movies and the theater. I/We hereby authorize such field trips for my/our child. I/We also understand that my/our child may participate in contact and other sports including basketball, baseball, soccer, softball, skiing, snowboarding, roller blading and the Special Olympics.

I/We also understand that, from time to time, my/our child will participate in an off-campus trip with staff members. For example, a student may go to a restaurant with staff for a meal, or a student may go shopping with staff at a supermarket.

I/We hereby authorize such off-campus trips for my/our child.

_____ **I/We have read the above form and understand all of its terms.**

_____ **I/We hereby give my/our consent to field trips under the conditions set forth in this form.**

_____ _____

(Parent/Guardian Signature) (Date)

(Please Read)

This curriculum is designed to enhance a positive self-image and view of one's progression into and through adolescence. The intention of this program is to help establish a relaxed and confident environment, which encourages students to openly discuss matters of sexuality.

Material presented is based on factual information with a focus on use of correct terminology. The ability to use proper terminology fosters understanding and knowledge of any subject matter. It also allows the students to move toward responsible decision making and control of their own sexuality.

Subject matter includes: General and Reproductive Anatomy & Physiology, Sexually Transmitted Diseases, Contraception, Disease Prevention, AIDS Education, Responsible Decision Making, Values, Relationships and Boundaries, Personal Body Safety/Abuse Prevention, Substance Abuse and Nutrition.

Each student receives 45 min. - 1 hr. per week of Health Education in the classroom setting. Subject matter is modified accordingly based on the developmental and chronological age needs of the child.

_____ I/We consent to this policy

_____ _____

(Parent/Guardian Signature) (Date)

Family Planning Consent

I/We, _____, the parent(s)/guardian(s)/Custodial agency of

(Student's name) _____, hereby give consent to the provisions by

Hillcrest Educational Centers, Inc. of family planning information to _____

(Student's Name)

I/We, _____ also consent to Hillcrest's provisions of, for referral

for family planning devices, medication and services concerning _____

(Student's name)

upon the request of _____

(Student's name)

_____ **I/We have read the above form and understand all of its terms. I/We hereby give my/our consent to the provision of family planning information and services under the conditions set forth in this form to** _____ *(Student's name).*

_____ _____

(Parent/Guardian Signature) (Date)

MEDICAL INSURANCE COVERAGE INFORMATION

(This form must be completely filled out)

Student's Name: _____

What type of medical insurance does student have? _____

Private Insurance: _____ Yes ***(attach copy of card)***

Name of Company: _____

Policy Number: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's Social Security Number: _____

Is there a prescription plan? _____ Yes _____ No

If Yes, attach copy of card and information about the plan.

Is there a dental plan? _____ Yes _____ No

Member services telephone: _____

State Medical Assistance Program: _____ Yes ***(attach copy of card)***

State: _____

ID Number/ Medicaid Client ID#: _____

Other: _____

Is student eligible for Title IV-E Benefits? _____ Yes _____ No

If Yes, sign following page and attach copy of birth certificate and social security card.

Is student receiving SSI Benefits? _____ Yes _____ No

If Yes, who is payee? _____

REMEMBER:

You must attach copies of the:

- *Current Insurance Card*
- *Birth Certificate*
- *Social Security card*

CERTIFICATION OF ELIGIBILITY OF TITLE IV-E FCAA RECIPIENT FOR MEDICAL ASSISTANCE

I. IDENTIFYING DATA

Child: _____ Gender: _____

Social Security No. _____ - _____ - _____

FOSTER PARENT(S), ADOPTIVE PARENT(S) OR RESIDENCE:

Hillcrest Educational Centers, Inc.
788 South Street
Pittsfield, MA 01201

II. STATUS OF IV-E ELIGIBILITY ***(please check applicable statement)***

_____ There are Title IV-E foster care payments being made on the child's behalf under Section 472 of the Social Security Act.

_____ There is a Title IV-E adoption assistance agreement in effect for this child under Section 473 of the Social Security Act.

Child is not automatically eligible for Medicaid because:

_____ Effective _____, Title IV-E foster care payments on the child's behalf under Section 472 of the Social Security have been discontinued.

_____ Effective _____, the Title IV-E adoption assistance agreement under Section 473 of the Social Security Act is no longer in effect for this child.

III. THIRD PARTY HEALTH INSURANCE INFORMATION ***(Please check as applicable)***

Child _____ has _____ does not have third party insurance coverage.

List sources of medical coverage or benefits: _____ SSI _____ SSA _____ VA _____ Campus

Private Insurance *(Specify):* _____

Policy Number: _____

___ Other *(Specify):* _____

IV. CHANGE OF ADDRESS

Effective: _____, Child/Family is moving to: _____

Number Street Apt. #

_____

City State Zip Code

Child's Medicaid coverage with _____ current state of residence _____

Title IV-E FCAA state will be discontinued effective: _____

V. ADDITIONAL INFORMATION

Any questions regarding this child's IV-E eligibility should be directed to:

Name: _____ Date: _____

Agency: _____ Phone: _____

Signature: _____

Consent to Continue Medications

PARENT/GUARDIAN CONSENT FORM

(Please Print)

I/We, _____ ,the parent(s) and/or guardian(s), hereby

give consent for my child, _____

(Student's Name)

to receive the currently prescribed medications that my child was taking at the time of his/her arrival at Hillcrest Educational Centers, Inc. ("Hillcrest"). I/We acknowledge that I/we have received sufficient information concerning such medication from other providers in order to provide informed consent.

I/We further understand that my child will receive a psychiatric evaluation shortly after his/her arrival at Hillcrest. I/We consent to such evaluation, and understand that my/our informed written consent will be obtained (absent an emergency) prior to any change in the medication for my/our child. I/We will also be notified of any dosage change.

I/We acknowledge that separate consent will not be required for any dosage changes within ranges of dosages to which I/we have consented.

Parent/Guardian Signature: _____ **Date:** _____

Note: Any youth under the age of 18 who has been placed under the guardianship of a state social service agency and requires antipsychotic medication will be admitted to Hillcrest Educational Centers only after an agreement is reached between the referring agency and HEC as to the financial responsibility for obtaining a Rogers Affidavit has been determined. Additionally, the funding agency will be required to participate in any necessary discussions, legal document completion, and potentially make court appearances related to the Rogers Affidavit.

Likewise, any adult student with a court-appointed guardian needing an antipsychotic medication will be admitted to Hillcrest only after a Rogers Affidavit has been determined. This will allow HEC to obtain the necessary Rogers Affidavit. Additionally, the court ordered guardian will be required to participate in any necessary discussions, legal document completion, and potentially make court appearances related to the Rogers Affidavit.

HEPATITIS B Vaccine Description

THE DISEASE: Hepatitis B is a viral infection caused by hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic, active hepatitis, cirrhosis, and liver cancer.

THE VACCINE - RECOMBIVAX HB: Recombivax HB vaccine is the first genetically designed vaccine for humans. The gene coding for hepatitis B surface antigen (HBSAG) is extracted from a laboratory strain of hepatitis B virus and implanted into a yeast cell. This yeast is common baker's yeast. This yeast cell replicates (along with the gene that encodes HBSAG). The HBSAG is extracted from the yeast cell and purified through numerous steps and formulated into a vaccine. The vaccine is free of association with human blood or blood products. Full immunization requires two doses of vaccine over a six-month period, although some persons may not develop immunity even after three doses. There is no evidence that the vaccine has ever caused hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of the immunization. The duration of protective effect of Recombivax HB is unknown at present, and the need for booster doses is not yet defined.

POSSIBLE SIDE EFFECTS: The incidence of side effects is low. The most common is a local reaction at the injection site. Less common are fatigue, weakness, nausea, headache, fever, and joint pain. The possibility exists that more serious side effects may be identified with more extensive use.

Student Immunization Consent - *Hepatitis B Vaccine*

I/We, _____ , the parent(s) and/or guardian(s), request that the Nursing personnel at Hillcrest Educational Centers, Inc. give _____ the Hepatitis B Vaccine for the purpose of immunization.

(Student name)

In giving the informed consent, I am aware of the following:

I/We have read the information sheet (included in this packet) about Hepatitis B, the vaccine and possible side effects. I/we acknowledge that I/we understand its contents. I/We am/are aware that the Hepatitis B Vaccine is not recommended for pregnant women. I/We acknowledge that there are no warrants or assurance with respect to the benefits or consequences of the immunization. I/We certify that I/we have read this consent form, or it has been read to me/us. I/We further certify that any questions have been answered to my/our satisfaction, with my/our full understanding. I/We desire no further disclosure of information.

I/We certify that I/we am/are the parent(s) or legal guardian(s) of the student named above:

_____ _____

(Parent/Guardian Signature) (Date)

If consenting person is the student:

I certify that I am 18 years of age or older: _____ _____

(Student's Signature) (Date)

Hepatitis B Vaccine Information Statement

is located in Appendix A

Varicella Virus Vaccine - Student Immunization Consent

(Please Print)

Student's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

I. Varicella Vaccine *(Chicken Pox Immunization)*

I give my consent for my child, _____,

to receive the varicella vaccine from the nursing personnel at Hillcrest Educational Centers, Inc.

In giving my consent, I certify to the following:

1. I certify that I have read and understand the attached information regarding the varicella vaccine and its side effects.
2. I certify that I have read Part II of this form and understand the alternatives for administration of the varicella vaccine:
3. I certify that I do not qualify for a religious or medical exemption.
4. I certify that I have read this consent form or it has been read to me and any questions have been answered to my satisfaction with my full understanding and I desire no further disclosure of information;
5. I certify that to the best of my knowledge my child has no medical condition that would interfere with the safe administration of the vaccine;
6. I certify that I am the parent or legal guardian of the child named above.

Signature: _____ Date Signed: _____

Relationship to child: _____

II. Alternatives to the Varicella Vaccine

If you chose not to have your child immunized against varicella by Hillcrest Educational Centers, by Massachusetts State law, you **must** provide one of the following:

1. Presentation of written documentation that your child meets the standards for medical or religious exemption as set forth in the Massachusetts General Laws.
2. Presentation of a physician statement that your child has a history of chicken pox disease.
3. Presentation of laboratory evidence of immunity.
4. Presentation of written documentation that the varicella vaccine was administered.
   (a) Under 13 years: One dose is required for all students receiving vaccine at less than 13 years of age.
   (b) 13 years or older: Two doses are required for students receiving their first dose of vaccine at 13 years of age or older.

Varicella (Chicken Pox) Vaccine Information Statement

is located in Appendix A

Hepatitis B and C - Authorization for Diagnostic Testing

I/We, _____, hereby give permission to Hillcrest Educational Centers, Inc. physicians, nursing staff, and facilities caring for Hillcrest Educational Centers ("Hillcrest")residents and staff to have _____ tested

(Student's Name)

for Hepatitis B and C, following any incident where my/our child exposes any staff and/or peer to resident's own bodily fluids. Hillcrest may also request testing for Hepatitis B and C when it has reasonable grounds to believe that the student is infected and may infect others.

Please Print Clearly

Full Name of Student: _____

Program Site: _____

Full Name of Parent/Guardian: _____

Relationship to Resident: _____

Telephone Number at Home: _____

Telephone Number at Work: _____

Signed: _____ _____

(Parent/Guardian Signature) *(Date)*

HIV - Authorization for Diagnostic Testing

I/We, _____, hereby give permission to Hillcrest Educational Centers, Inc. ("Hillcrest") physicians, nursing staff, and facilities caring for Hillcrest Educational Centers residents and staff to have _____ tested for
(Student's Name)
HIV following any incident where my/our child exposes any staff and/or peer to resident's own bodily fluids. Hillcrest may also request testing for HIV when it has reasonable grounds to believe that the student is infected and may infect others, and to protect the health and safety of other residents.

Any results from HIV testing (HTLV-III test for antibody or antigen) will be kept separately from the student's core medical file at the medical facility where the testing is done.

If testing is done, I/we hereby allow the results of _____ 's HIV test to be released to Hillcrest and its Occupational Health Department. I/We understand that Hillcrest will not disclose the results of the HIV test to any other source without first obtaining my/our informed written consent.

Full Name of Student: _____

Program Site: _____

Full Name of Parent/Guardian: _____

Relationship to Resident: _____

Telephone Number at Home: _____

Telephone Number at Work: _____

Signed: _____ _____
(Parent/Guardian Signature) *(Date)*

Student Immunization Consent

DPT, MMR, IPV

I/We, _____ , parent(s)/guardian(s) of

_____ request that the Nursing

(Student name)

personnel at Hillcrest Educational Centers, Inc. give the following vaccine(s).

YOU MUST CHECK EACH VACCINE YOU ARE CONSENTING TO BELOW

_____ Td or DPT if under age 7 or Td if over age 7. (Diphtheria, Pertussis, Tetanus)

_____ MMR (Measles, Mumps, Rubella)

_____ IPV (Polio)

I/We consent to these vaccines for the purposes of immunization against these diseases if indicated by records available and in accordance with Massachusetts Department of Health guidelines.

In giving consent I/We am/are aware of the following:

1. I have read and understood the information about these vaccines and possible side effects included in this packet.
2. I acknowledge that there are no warranties or assurances with respect to the benefits or consequences of these immunizations.
3. I certify that I have read this consent form, or it has been read to me. I further certify that any questions have been answered to my satisfaction, with my full understanding. I desire no further disclosure of information.

I certify that I am the parent or legal guardian of the student named above.

_____ _____ _____

(Signature)	(Witness)	(Date)

The following Vaccine Information Statements

are located in Appendix A

Td (Tetanus & Diptheria)

DTaP (Diptheria, Tetanus & Pertussis)

MMR (Measles, Mumps & Rubella)

Polio

'

MEDICAL REQUIREMENTS FOR ADMISSION

The following is a listing of medical information/requirements for Hillcrest Educational Centers, Inc., which must be submitted prior to admission of new students. We have provided our forms for some of these items for your convenience. You may submit records on your forms if you prefer.

- Documentation/verification of medical insurance and a copy of the child's birth certificate and Social Security card.
- Request signed by the parent(s)/guardian(s) to continue present medications, including prescription(s) or physicians orders for medications. **A 30-Day supply of medication(s) (combination of medication(s) and prescriptions) is required**.
- Report of Hepatitis A, B and C screening within the prior month with lab results.
- Results of most recent laboratory testing and other indicated special testing (i.e.: EEG, EKG, Baseline EKG etc.).
- Reports of most recent vision, hearing, and dental examinations, including optical prescription if glasses are worn.
- Up-to-date medical history including allergies.
- Complete physical examination **within the past twelve months**.
- Records of Immunizations, including childhood immunizations.
- Physician's statement that child is free of communicable & infectious disease included on Physical form.
- Record of TB risk assessment completed within the last 60 days indicating low-risk.

Hillcrest reserves the right to accept without complete submission of this data. However, all necessary documents will be required in order to admit a student.

Hillcrest Educational Centers is unable to provide braces for children in its care. It is unlikely that a child would reside at Hillcrest for the entire duration of the orthodontic process. The treatment of braces requires that the process begins and ends with the same orthodontist.

For children entering Hillcrest with braces the parent/guardian must be responsible for the ongoing follow-up required, including transportation.

Pre-Placement Physical Exam

Name of Student: _____ **Date of Birth:** _____

Diagnoses:

_____
_____
_____
_____
_____

Current Medications: (*please attach signed prescriptions)*

_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____
_____

Past Medical History:

_____
_____
_____
_____
_____

Prenatal/Birth/Development History:

_____
_____
_____
_____

Family History:

_____
_____
_____
_____
_____

Social/Environmental History:

_____
_____
_____
_____

Prior Consultations with Sub-Specialists – e.g. Neurology, Endocrinology, Cardiology (*Please attach to exam form)*

_____
_____
_____
_____
___

EKG Date: _____ Findings:
_____

EEG Date: _____ Findings:
_____

Pertinent Lab and Radiological Exams including CT or MRI:
_____
_____
_____
_____
_____
___

Pre-Placement Physical Exam Page 2 of 2

Name of Student: _____ **Date of Birth:** _____

Physical Exam Date:

_____

_____

Wt: _____ %: _____ Ht: _____ %: _____ BMI: _____ %: _____ BP: _____

Skin: _____ Lungs:

_____

HEENT: _____ Heart:

_____

Neck: _____ Abdomen:

_____

Tanner Stage: _____ If female: Menstruating Y N

Genito-Urinary:

_____

_____

Musculo-Skeletal:

_____

_____

Scoliosis: Passed / Following / Referred

Neurologic:

_____

_____

Vision: _____ / _____ ***Wears: glasses / contacts Passed / Following / Referred***

Hearing (fluid/tubes/deficit): _____ ***Passed / Following / Referred***

General appearance/demeanor/health:

_____

▫ Lead:

_____

_____

TB Risk

▫ PPD date: _____ Result: +/- _____

OR

▫ This student has been assessed within the last 60 days to be at **LOW risk for TB** and therefore a PPD test is not recommended.

▫ This student may fully participate in school programs without restrictions.

▫ This student has the following restrictions for program participation at school:

As examining physician, my signature on this form indicates that I have completed an exam and at this time the above individual is free of communicable and infectious diseases.

Pre-Placement Physical Exam Page 2 of 2

Name of physician (*please print*): _____ Office phone: _____

_____

_____ _____

(Signature of Physician/PA/NP) *(Date)*

PLEASE: **1. ATTACH A COPY OF IMMUNIZATION RECORD OR COMPLETE THE *CERTIFICATE OF IMMUNIZATION*.**

2. FOR STUDENTS WITH SIGNIFICANT ALLERGIES OR ASTHMA, PLEASE ATTACH AN EXPLANATION OF REACTION AND TREATMENT PLAN.

***ALSO COMPLETE *PRESCRIPTION MEDICATION CONSENT* FOR EPIPEN OR INHALERS FOR SCHOOL USE**

Pediatric TB Risk Assessment Form

(To be completed by medical provider)

The purpose of the TB Risk Assessment Form is to identify children who may be at increased risk for tuberculosis (TB) and may require evaluation and testing. ***A child with any risk factor described below is a candidate for TB testing, unless there is written documentation of a previous positive TB test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]).***

Child's _____ DO _____ Date:

TB Risk Assessment	Yes	No
Was the child born in Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East? In what country was the child born? _____	☐	☐
Has the child lived or traveled in Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than one month?	☐	☐
In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	☐	☐
Have any members of the child's household come to the United States from another country?	☐	☐
Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	☐	☐

Test for TB

Test, using a TST or IGRA, only those infants and children identified to be at risk of exposure to TB. Do not test infants and children at low risk for TB.

- IGRA is the preferred test for children 5 years of age and older with a history of BCG vaccination
- Use the Mantoux tuberculin skin test (5 TU PPD) for children of any age.

Report TB

Report newly diagnosed cases of latent TB infection and suspected or confirmed TB disease to the Massachusetts Department of Public Health.

http://www.mass.gov/eohhs/gov/departments/dph/programs/id/isis/case-report-forms.html

Resources

Brochure "What Parents Need to Know About Tuberculosis (TB) Infection in Children", New Jersey Medical School Global Tuberculosis Institute http://globaltb.njms.rutgers.edu/downloads/products/tbpedsbrochure.pdf

Screening Infants and Children for Tuberculosis in Massachusetts, MDPH 2014 http://www.mass.gov/eohhs/docs/dph/cdc/tb/recommendations-screening-children-tb.pdf

CDC recommendations on TB evaluation, testing and treatment in children http://www.cdc.gov/tb/topic/populations/TBinChildren/default.htm

CDC Guidelines for the Prevention and Treatment of Opportunistic Infections among HIV-Exposed and HIV-Infected Children. MMWR September 2009 http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5811a1.htm

MDPH supported TB clinics http://www.mass.gov/eohhs/docs/dph/cdc/tb/regional-clinic-list.pdf

Medical Provider Signature: _____ ***Date:*** _____

Hillcrest Educational Centers

Rev. 4/6/18

Hillcrest
Educational Centers

Consent for Dental Treatment at Hillcrest Dental Office

I/We, _____ (parent(s)/guardian(s), authorize Hillcrest's dental team to perform dental treatment as deemed necessary on _____ (Student's Name) after a dental visit exam.

1. This is my consent to the treatment indicated by examination and any other oral surgery deemed necessary of advisable to the planned operation. I also agree to the use of local anesthetics. I am aware of the following complications of surgery, which include, but are not limited to:
    - loss of the teeth that are periodontally involved;
    - problems with anesthesia, drugs, and medications;
    - the hazard(s) of surgery include pain, bleeding, swelling, infection, possible permanent numbness or tingling of the lips, face, gums or tongue;
    - possible loss of adjacent teeth;
    - sensitivity to temperature change;
    - teeth may appear longer and/or larger;
    - the extraction of third molars presents a minimal possibility of fracture of the lower jaw or complications with the maxillary sinus;
    - the augmentation of artificial, natural or human bone substance when and if it is necessary and/or advisable.

2. I understand that the dental care for my student will include regular oral hygiene appointments and that my student will be instructed in oral hygiene self-care, and my student will be responsible to follow his/her dental hygiene self-care.

3. To my knowledge, I have given an accurate report of my student's physical and mental history. I have also reported any prior allergic reactions to drugs, food, insect bites, anesthetics, pollens, blood or body disease, gum or skin reactions, abnormal bleeding or any other condition related to health.

4. I consent to photography, filming, recording, x-rays, and additional professional staff observing the procedure to be performed for the advancement of dentistry provided my student's identity is not revealed.

5. I certify that I have read and fully understand this authorization for treatment and that all blanks on this form that are required are filled in.

_____ _____

Signature of Parent / Guardian Date

_____ _____

Signature of Witness Date

Hillcrest
Educational Centers

Rev. 4/6/18

Hillcrest Dental Care – Student Registration Sheet

Campus _____

Patient Information

Name _____ Social Security# _____

Last First Middle

Mailing Address _____

Street/P.O. Box City/Town State Zip Code

Physical Address _____

Street City/Town State Zip Code

Home Phone _____ Alternate Contact Number _____

Gender _____ DOB _____ Current Age _____ Marital Status _____

Parent/Guardian Name _____ Phone# _____

Parent/Guardian Address _____

Dental Insurance Information

Insurance Company _____ Phone# _____

Claims Mailing Address _____

Street/P.O. Box City/Town State Zip Code

Hillcrest
Educational Centers

Subscriber Name _____ Relationship to Patient _____

Subscriber DOB _____ Subscriber SS# and/or ID _____

Group# _____ Effective Date of Plan _____

Name of Employer _____ Work Phone _____

Rev. 4/6/18

HEPATITIS A Vaccine Description

THE DISEASE: Hepatitis A, once called "infectious hepatitis," is a liver infection caused by the hepatitis A virus. It is highly contagious and can be spread easily from one person to another. Anyone can get hepatitis A, but it is more common in children. The disease is rarely fatal and does not cause chronic (long-term) liver disease. Once a person has had hepatitis A, he or she cannot get it again. The hepatitis A virus is spread through stool (by the fecal-oral route). This means the disease is spread by putting something in the mouth that has been contaminated with the stool of an infected person. There is a vaccine to prevent hepatitis A.

THE VACCINE – VAQTA/ Havrix: Havrix and VAQTA are hepatitis A vaccines indicated for patients older than the age of 12 months. Typically, these vaccines are administered as two injections given six to 18 months apart. Patients receive this immunization as an intramuscular injection in either the thigh or upper arm.

POSSIBLE SIDE EFFECTS: Getting hepatitis A vaccine is much safer than getting the disease. Mild problems may include localized soreness, headache, loss of appetite or tiredness lasting for a few days. The possibility exists that more serious allergic reaction may occur with administration of any vaccine.

Student Immunization Consent - *Hepatitis A Vaccine*

I/We, _____ , (parent(s)/guardian(s), of

_____ request that the Nursing personnel at

(Student Name)

Hillcrest Educational Centers, Inc. give my child the Hepatitis A Vaccine for the purpose of immunization.

In giving the informed consent, I am aware of the following:

I/We have read the information sheet, included in this packet, about Hepatitis A, the vaccine and possible side effects. I/we acknowledge I/we understand its contents. I/We am/are aware that the Hepatitis A Vaccine is not recommended for pregnant women. I/We acknowledge that there are no warrants or assurance with respect to the benefits or consequences of the immunization. I/We certify that I/we have read this consent form, or it has been read to me/us. I/We further certify that any questions have been answered to my/our satisfaction, with my/our full understanding. I/We desire no further disclosure of information.

I/We certify that I/we am/are the parent(s) or legal guardian(s) of the student named above:

(Parent/Guardian Signature) _____

If consenting person is the student:

I certify that I am 18 years of age or older: _____

Rev. 4/6/18

Hepatitis A Vaccine Information Statement

is located in Appendix A

Hillcrest
Educational Centers

MENINGOCOCCAL VACCINATION CONSENT

Student: _____ **DOB:** _____

I/We, _____, the parent(s)/

legal guardian(s) / custodial agency of _____

(Student's Name)

have been given the opportunity to read over the informational material, included in this packet, about Meningococcal Disease and Vaccination.

I/We agree to have _____ receive the vaccine.

(Student's Name)

I understand that, in the event of a shortage of the vaccine, _____

(Student's Name)

may be unable to receive it at present.

I also understand that when the vaccine becomes available to Hillcrest Educational Centers, Inc.,

_____ will receive the vaccine.

(Student's Name)

Parent/Legal Guardian/Custodial Agency: _____

(Parent/Legal Guardian/Custodial Agency Signature)

Date: _____

Rev. 4/6/18

Hillcrest
Educational Centers

Meningococcal ACWY and Meningococcal B
Vaccine Information Statements

are located in Appendix A

Hillcrest
Educational Centers

GARDASIL (HPV) VACCINATION CONSENT

Student: _____ **DOB:** _____

I/We, _____, the parent(s)/

legal guardian(s) / custodial agency of _____

(Student's Name)

have been given the opportunity to read over the informational material, included in this packet, regarding the Gardasil Vaccination to prevent Human Papillomavirus..

I/We agree to have _____ receive the vaccine which

(Student's Name)

consists of three doses given as a first injection, a second injection two months later, and the third injection at six months following the first.

Parent/Legal Guardian/Custodial Agency: _____

(Parent/Legal Guardian/Custodial Agency Signature)

Date: _____

Hillcrest
Educational Centers

HPV (Human Papillomavirus) Vaccine Information Statement

is located in Appendix A

Hillcrest
Educational Centers

POLICY CONCERNING SERVICE TO PREGNANT FEMALES

HEC residential programs are *not* designed to provide care and treatment for young women:

- Who are pregnant at the time they are referred to Hillcrest;
- Who become pregnant while waiting for placement at a Hillcrest program;
- Or who are in placement at a Hillcrest program at the time they become pregnant.

A young woman who is, or who may be pregnant at the time she is referred will not be considered for admission to Hillcrest.

If a Hillcrest student becomes pregnant while residing in a HEC program, Hillcrest will work with the student, the student's parent or guardian, and with involved and/or responsible agencies to identify the student's needs and options. Should the student choose to bring the pregnancy to term, Hillcrest will work with the student's custodial agency to locate appropriate residential options to which the student may transfer. Such residential options would have, for example, the capability and resources to prepare a teen parent for the physical, social, and emotional responsibilities of pregnancy, childbirth, parenthood, and, when appropriate, care and protection of the child.

In any case, it must be understood that remaining at Hillcrest is <u>not</u> an option for a pregnant student, and transfer from Hillcrest must be affected within 30 days of Hillcrest's notice of intent to discharge.

Hillcrest
Educational Centers

Please note that Parents / Legal Guardians are entitled to a copy of Hillcrest's Policy & Procedure manual upon request.

BEFORE SUBMITTING DOCUMENTS, PLEASE REVIEW THE FOLLOWING TO ENSURE THAT ALL REQUISITES AND NECESSARY BACKUP DOCUMENTS ARE INCLUDED IN THIS ADMISSION PACKET FOR:

- ☐ ***All Consents have been signed.***
- ☐ IEP ***(most recent)***
- ☐ Psychological Evaluation ***(most recent)***
- ☐ Psychiatric Evaluation ***(most recent)***
- ☐ Documentation/verification of medical & dental insurance, as well as copy of child's:
  - **** Insurance Cards (medical & dental)***
  - **** Birth Certificate***
  - **** Social Security Card.***
- ***Records of Immunizations***, including childhood immunizations.
- ☐ Complete physical examination ***within the past twelve months*** and up-to-date medical history, including allergies.
- ☐ **EXAMINING PHYSICIAN TO SIGN** (page 21) –***this section must be completely filled out & signed. This is the Physician's statement that child is free of communicable & infectious disease.***
- ☐ Records of results of the TB testing completed ***within the last 12 months***.
  Or record of TB Risk Assessment, ***completed within the last 60 days,*** indicating low-risk.
- ☐ Meningococcal Vaccination Consent **or** Waiver to be signed **or** proof of vaccination.
- Request signed by the parent/guardian to continue present medication(s).
- ***Prescription(s) from ordering physician for all of child's medication(s). Hillcrest requires child arrives with at least 30 days supply of all medication (combination of prescriptions and meds).***
- ☐ Results of most recent laboratory testing and other indicated special testing (i.e.: EEG, EKG, Baseline EKG, Hepatitis A, B and C screening within the prior month with lab results, etc.).
- ☐ Reports of most recent vision, hearing, and dental examinations, including optical prescription if glasses are worn.
- ☐ ***Review of Clothing / Personal Belongings List.***

Send Completed Packet Directly To:

Jackie Mercado, Admissions Coordinator
c/o Hillcrest Educational Centers, Inc.
788 South Street
Pittsfield, Massachusetts 01201

Rev. 4/6/18

Appendix A

Vaccine Information Statements

Hepatitis B Vaccine:
What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Hepatitis B vaccine can prevent **hepatitis B.** Hepatitis B is a liver disease that can cause mild illness lasting a few weeks, or it can lead to a serious, lifelong illness.

- **Acute hepatitis B infection** is a short-term illness that can lead to fever, fatigue, loss of appetite, nausea, vomiting, jaundice (yellow skin or eyes, dark urine, clay colored bowel movements), and pain in the muscles, joints, and stomach.
- **Chronic hepatitis B infection** is a long-term illness that occurs when the hepatitis B virus remains in a person's body. Most people who go on to develop chronic hepatitis B do not have symptoms, but it is still very serious and can lead to liver damage (cirrhosis), liver cancer, and death. Chronically-infected people can spread hepatitis B virus to others, even if they do not feel or look sick themselves.

Hepatitis B is spread when blood, semen, or other body fluid infected with the hepatitis B virus enters the body of a person who is not infected. People can become infected through:

- Birth (if a mother has hepatitis B, her baby can become infected)
- Sharing items such as razors or toothbrushes with an infected person
- Contact with the blood or open sores of an infected person
- Sex with an infected partner
- Sharing needles, syringes, or other drug injection equipment
- Exposure to blood from needlesticks or other sharp instruments

Most people who are vaccinated with hepatitis B vaccine are immune for life.

2 Hepatitis B vaccine

Hepatitis B vaccine is usually given as 2, 3, or 4 shots.

Infants should get their first dose of hepatitis B vaccine at birth and will usually complete the series at 6 months of age (sometimes it will take longer than 6 months to complete the series).

Children and adolescents younger than 19 years of age who have not yet gotten the vaccine should also be vaccinated.

Hepatitis B vaccine is also recommended for certain **unvaccinated adults:**

- People whose sex partners have hepatitis B
- Sexually active persons who are not in a long-term monogamous relationship
- Persons seeking evaluation or treatment for a sexually transmitted disease
- Men who have sexual contact with other men
- People who share needles, syringes, or other drug-injection equipment
- People who have household contact with someone infected with the hepatitis B virus
- Health care and public safety workers at risk for exposure to blood or body fluids
- Residents and staff of facilities for developmentally disabled persons
- Persons in correctional facilities
- Victims of sexual assault or abuse
- Travelers to regions with increased rates of hepatitis B
- People with chronic liver disease, kidney disease, HIV infection, infection with hepatitis C, or diabetes
- Anyone who wants to be protected from hepatitis B

Hepatitis B vaccine may be given at the same time as other vaccines.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an allergic reaction after a previous dose of hepatitis B vaccine, or has any severe, life-threatening allergies.

In some cases, your health care provider may decide to postpone hepatitis B vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting hepatitis B vaccine.

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- Soreness where the shot is given or fever can happen after hepatitis B vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call 1-800-338-2382 to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC's www.cdc.gov/vaccines

Vaccine Information Statement (Interim)
Hepatitis B Vaccine

Office use only

8/15/2019 | 42 U.S.C. § 300aa-26

Varicella (Chickenpox) Vaccine:

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Varicella vaccine can prevent chickenpox.

Chickenpox can cause an itchy rash that usually lasts about a week. It can also cause fever, tiredness, loss of appetite, and headache. It can lead to skin infections, pneumonia, inflammation of the blood vessels, and swelling of the brain and/or spinal cord covering, and infections of the bloodstream, bone, or joints. Some people who get chickenpox get a painful rash called shingles (also known as herpes zoster) years later.

Chickenpox is usually mild but it can be serious in infants under 12 months of age, adolescents, adults, pregnant women, and people with a weakened immune system. Some people get so sick that they need to be hospitalized. It doesn't happen often, but people can die from chickenpox.

Most people who are vaccinated with 2 doses of varicella vaccine will be protected for life.

2 Varicella vaccine

Children need 2 doses of varicella vaccine, usually:

- First dose: 12 through 15 months of age
- Second dose: 4 through 6 years of age

Older children, adolescents, and adults also need 2 doses of varicella vaccine if they are not already immune to chickenpox.

Varicella vaccine may be given at the same time as other vaccines. Also, a child between 12 months and 12 years of age might receive varicella vaccine together with MMR (measles, mumps, and rubella) vaccine in a single shot, known as MMRV. Your health care provider can give you more information.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of varicella vaccine, or has any severe, life-threatening allergies.**
- Is pregnant, or thinks she might be pregnant.
- Has a **weakened immune system**, or has a **parent, brother, or sister with a history of hereditary or congenital immune system problems.**
- **Is taking salicylates** (such as aspirin).
- Has recently **had a blood transfusion or received other blood products.**
- Has **tuberculosis.**
- Has **gotten any other vaccines in the past 4 weeks.**

In some cases, your health care provider may decide to postpone varicella vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting varicella vaccine.

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- Sore arm from the injection, fever, or redness or rash where the shot is given can happen after varicella vaccine.
- More serious reactions happen very rarely. These can include pneumonia, infection of the brain and/or spinal cord covering, or seizures that are often associated with fever.
- In people with serious immune system problems, this vaccine may cause an infection which may

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

be life-threatening. People with serious immune system problems should not get varicella vaccine.

It is possible for a vaccinated person to develop a rash. If this happens, the varicella vaccine virus could be spread to an unprotected person. Anyone who gets a rash should stay away from people with a weakened immune system and infants until the rash goes away. Talk with your health care provider to learn more.

Some people who are vaccinated against chickenpox get shingles (herpes zoster) years later. This is much less common after vaccination than after chickenpox disease.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1 800 338 2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)
Varicella Vaccine

Office use only

8/15/2019 | 42 U.S.C. § 300aa-26

Revised: 2/18/2008

DTaP (Diphtheria, Tetanus, Pertussis) Vaccine: *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

DTaP vaccine can help protect your child from **diphtheria, tetanus, and pertussis.**

- **DIPHTHERIA** (D) can cause breathing problems, paralysis, and heart failure. Before vaccines, diphtheria killed tens of thousands of children every year in the United States.
- **TETANUS** (T) causes painful tightening of the muscles. It can cause "locking" of the jaw so you cannot open your mouth or swallow. About 1 person out of 5 who get tetanus dies.
- **PERTUSSIS** (aP), also known as Whooping Cough, causes coughing spells so bad that it is hard for infants and children to eat, drink, or breathe. It can cause pneumonia, seizures, brain damage, or death.

Most children who are vaccinated with DTaP will be protected throughout childhood. Many more children would get these diseases if we stopped vaccinating.

2 DTaP vaccine

Children should usually get 5 doses of DTaP vaccine, one dose at each of the following ages:

- 2 months
- 4 months
- 6 months
- 15–18 months
- 4–6 years

DTaP may be given at the same time as other vaccines. Also, sometimes a child can receive DTaP together with one or more other vaccines in a single shot.

3 Some children should not get DTaP vaccine or should wait

DTaP is only for children younger than 7 years old. DTaP vaccine is not appropriate for everyone—a small number of children should receive a different vaccine that contains only diphtheria and tetanus instead of DTaP.

Tell your health care provider if your child:

- Has had an **allergic reaction after a previous dose of DTaP**, or has any severe, life threatening **allergies.**
- Has had a **coma or long repeated seizures within 7 days after a dose of DTaP.**
- Has **seizures or another nervous system problem.**
- Has had a condition called **Guillain-Barré Syndrome (GBS)**
- Has had **severe pain or swelling after a previous dose** of DTaP or DT vaccine.

In some cases, your health care provider may decide to postpone your child's DTaP vaccination to a future visit.

Children with minor illnesses, such as a cold, may be vaccinated. Children who are moderately or severely ill should usually wait until they recover before getting DTaP vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Redness, soreness, swelling, and tenderness where the shot is given are common after DTaP.
- Fever, fussiness, tiredness, poor appetite, and vomiting sometimes happen 1 to 3 days after DTaP vaccination.
- More serious reactions, such as seizures, non-stop crying for 3 hours or more, or high fever (over 105°F) after DTaP vaccination happen much less often. Rarely, the vaccine is followed by swelling of the entire arm or leg, especially in older children when they receive their fourth or fifth dose.
- Long-term seizures, coma, lowered consciousness, or permanent brain damage happen extremely rarely after DTaP vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the child leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the child to the nearest hospital.

For other signs that concern you, call your child's health care provider.

Serious reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor will usually file this report, or you can do it yourself. Visit **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, it does not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (1-800-CDC-INFO) or
  - Visit **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)

DTaP (Diphtheria, Tetanus, Pertussis) Vaccine

08/24/2018 | 42 U.S.C. § 300aa-26

Revised: 2/18/2008

MMR Vaccine (Measles, Mumps, and Rubella): *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

MMR vaccine can prevent **measles**, **mumps**, and **rubella**.

- MEASLES (M) can cause fever, cough, runny nose, and red, watery eyes, commonly followed by a rash that covers the whole body. It can lead to seizures (often associated with fever), ear infections, diarrhea, and pneumonia. Rarely, measles can cause brain damage or death.
- MUMPS (M) can cause fever, headache, muscle aches, tiredness, loss of appetite, and swollen and tender salivary glands under the ears. It can lead to deafness, swelling of the brain and/or spinal cord covering, painful swelling of the testicles or ovaries, and, very rarely, death.
- RUBELLA (R) can cause fever, sore throat, rash, headache, and eye irritation. It can cause arthritis in up to half of teenage and adult women. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects.

Most people who are vaccinated with MMR will be protected for life. Vaccines and high rates of vaccination have made these diseases much less common in the United States.

2 MMR vaccine

Children need 2 doses of MMR vaccine, usually:

- First dose at 12 through 15 months of age
- Second dose at 4 through 6 years of age

Infants who will be traveling outside the United States when they are between 6 and 11 months of age should get a dose of MMR vaccine before travel. The child should still get 2 doses at the recommended ages for long-lasting protection.

Older children, adolescents, and adults also need 1 or 2 doses of MMR vaccine if they are not already immune to measles, mumps, and rubella. Your health care provider can help you determine how many doses you need.

A third dose of MMR might be recommended in certain mumps outbreak situations.

MMR vaccine may be given at the same time as other vaccines. Children 12 months through 12 years of age might receive MMR vaccine together with varicella vaccine in a single shot, known as MMRV. Your health care provider can give you more information.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of MMR or MMRV vaccine**, or has any **severe, life-threatening allergies.**
- Is **pregnant**, or thinks she might be pregnant.
- Has a **weakened immune system**, or has a parent, brother, or sister with a **history of hereditary or congenital immune system problems.**
- Has ever had a **condition that makes him or her bruise or bleed easily.**
- Has recently **had a blood transfusion or received other blood products.**
- Has **tuberculosis.**
- Has gotten **any other vaccines in the past 4 weeks.**

In some cases, your health care provider may decide to postpone MMR vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting MMR vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Soreness, redness, or rash where the shot is given and rash all over the body can happen after MMR vaccine.
- Fever or swelling of the glands in the cheeks or neck sometimes occur after MMR vaccine.
- More serious reactions happen rarely. These can include seizures (often associated with fever), temporary pain and stiffness in the joints (mostly in teenage or adult women), pneumonia, swelling of the brain and/or spinal cord covering, or temporary low platelet count which can cause unusual bleeding or bruising.
- In people with serious immune system problems, this vaccine may cause an infection which may be life threatening. People with serious immune system problems should not get MMR vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9 1 1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (**1-800-CDC-INFO**) or
  - Visit CDC's **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)
MMR Vaccine

8/15/2019 | 42 U.S.C. § 300aa-26

Revised: 2/18/2008

Polio Vaccine:
What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Polio vaccine can prevent polio.

Polio (or poliomyelitis) is a disabling and life-threatening disease caused by poliovirus, which can infect a person's spinal cord, leading to paralysis.

Most people infected with poliovirus have no symptoms, and many recover without complications. Some people will experience sore throat, fever, tiredness, nausea, headache, or stomach pain.

A smaller group of people will develop more serious symptoms that affect the brain and spinal cord:
- Paresthesia (feeling of pins and needles in the legs),
- Meningitis (infection of the covering of the spinal cord and/or brain), or
- Paralysis (can't move parts of the body) or weakness in the arms, legs, or both.

Paralysis is the most severe symptom associated with polio because it can lead to permanent disability and death.

Improvements in limb paralysis can occur, but in some people new muscle pain and weakness may develop 15 to 40 years later. This is called post-polio syndrome.

Polio has been eliminated from the United States, but it still occurs in other parts of the world. The best way to protect yourself and keep the United States polio-free is to maintain high immunity (protection) in the population against polio through vaccination.

2 Polio vaccine

Children should usually get 4 doses of polio vaccine, at 2 months, 4 months, 6–18 months, and 4–6 years of age.

Most adults do not need polio vaccine because they were already vaccinated against polio as children. Some adults are at higher risk and should consider polio vaccination, including:
- people traveling to certain parts of the world,
- laboratory workers who might handle poliovirus, and
- health care workers treating patients who could have polio.

Polio vaccine may be given as a stand-alone vaccine, or as part of a combination vaccine (a type of vaccine that combines more than one vaccine together into one shot).

Polio vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:
- **Has had an allergic reaction after a previous dose of polio vaccine, or has any severe, life-threatening allergies.**

In some cases, your health care provider may decide to postpone polio vaccination to a future visit.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting polio vaccine.

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- A sore spot with redness, swelling, or pain where the shot is given can happen after polio vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

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7 How can I learn more?

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  - Visit CDC's website at www.cdc.gov/vaccines

Vaccine Information Statement (Interim)
Polio Vaccine

10/30/2019 | 42 U.S.C. § 300aa-26

Revised: 2/18/2008

VACCINE INFORMATION STATEMENT

Hepatitis A Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de Información Sobre Vacunas están Disponibles en Español y en muchos otros idiomas. Visite http://www.immunize.org/vis

1 What is hepatitis A?

Hepatitis A is a serious liver disease caused by the hepatitis A virus (HAV). HAV is found in the stool of people with hepatitis A.

It is usually spread by close personal contact and sometimes by eating food or drinking water containing HAV. A person who has hepatitis A can easily pass the disease to others within the same household.

Hepatitis A can cause:

- "flu-like" illness
- jaundice (yellow skin or eyes, dark urine)
- severe stomach pains and diarrhea (children)

People with hepatitis A often have to be hospitalized (up to about 1 person in 5).

Adults with hepatitis A are often too ill to work for up to a month.

Sometimes, people die as a result of hepatitis A (about 3-6 deaths per 1,000 cases).

Hepatitis A vaccine can prevent hepatitis A.

2 Who should get hepatitis A vaccine and when?

WHO?

Some people should be routinely vaccinated with hepatitis A vaccine:

- All children between their first and second birthdays (12 through 23 months of age).
- Anyone 1 year of age and older traveling to or working in countries with high or intermediate prevalence of hepatitis A, such as those located in Central or South America, Mexico, Asia (except Japan), Africa, and eastern Europe. For more information see www.cdc.gov/travel.
- Children and adolescents 2 through 18 years of age who live in states or communities where routine vaccination has been implemented because of high disease incidence.
- Men who have sex with men.
- People who use street drugs.
- People with chronic liver disease.
- People who are treated with clotting factor concentrates.
- People who work with HAV-infected primates or who work with HAV in research laboratories.
- Members of households planning to adopt a child, or care for a newly arriving adopted child, from a country where hepatitis A is common.

Other people might get hepatitis A vaccine in certain situations (ask your doctor for more details):

- Unvaccinated children or adolescents in communities where outbreaks of hepatitis A are occurring.
- Unvaccinated people who have been exposed to hepatitis A virus.
- Anyone 1 year of age or older who wants protection from hepatitis A.

Hepatitis A vaccine is not licensed for children younger than 1 year of age.

WHEN?

For children, the first dose should be given at 12 through 23 months of age. Children who are not vaccinated by 2 years of age can be vaccinated at later visits.

For others at risk, the hepatitis A vaccine series may be started whenever a person wishes to be protected or is at risk of infection.

For travelers, it is best to start the vaccine series at least one month before traveling. (Some protection may still result if the vaccine is given on or closer to the travel date.)

Some people who cannot get the vaccine before traveling, or for whom the vaccine might not be effective, can get a shot called immune globulin (IG). IG gives immediate, temporary protection.

Two doses of the vaccine are needed for lasting protection. These doses should be given at least 6 months apart.

Hepatitis A vaccine may be given at the same time as other vaccines.

3 Some people should not get hepatitis A vaccine or should wait.

- Anyone who has ever had a severe (life threatening) allergic reaction to a previous dose of hepatitis A vaccine should not get another dose.
- Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine. **Tell your doctor if you have any severe allergies,** including a severe allergy to latex. All hepatitis A vaccines contain alum, and some hepatitis A vaccines contain 2-phenoxyethanol.
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover. Ask your doctor. People with a mild illness can usually get the vaccine.
- Tell your doctor if you are pregnant. Because hepatitis A vaccine is inactivated (killed), the risk to a pregnant woman or her unborn baby is believed to be very low. But your doctor can weigh any theoretical risk from the vaccine against the need for protection.

4 What are the risks from hepatitis A vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of hepatitis A vaccine causing serious harm, or death, is extremely small.

Getting hepatitis A vaccine is much safer than getting the disease.

Mild problems

- soreness where the shot was given *(about 1 out of 2 adults, and up to 1 out of 6 children)*
- headache *(about 1 out of 6 adults and 1 out of 25 children)*
- loss of appetite *(about 1 out of 12 children)*
- tiredness *(about 1 out of 14 adults)*

If these problems occur, they usually last 1 or 2 days.

Severe problems

- serious allergic reaction, within a few minutes to a few hours after the shot *(very rare)*.

5 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or unusual behavior. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or you can file this report through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not provide medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) was created in 1986.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**.

7 How can I learn more?

- Ask your doctor. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - **Call 1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)

Hepatitis A Vaccine

10/25/2011

42 U.S.C. § 300aa-26

Office Use Only

VACCINE INFORMATION STATEMENT

Meningococcal ACWY Vaccine:

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Meningococcal ACWY vaccine can help protect against meningococcal disease caused by serogroups A, C, W, and Y. A different meningococcal vaccine is available that can help protect against serogroup B.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

Anyone can get meningococcal disease but certain people are at increased risk, including:

- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of *N. meningitidis*, the bacteria that cause meningococcal disease
- People at risk because of an outbreak in their community

2 Meningococcal ACWY vaccine

Adolescents need 2 doses of a meningococcal ACWY vaccine:

- First dose: 11 or 12 year of age
- Second (booster) dose: 16 years of age

In addition to routine vaccination for adolescents, meningococcal ACWY vaccine is also recommended for certain groups of people:

- People at risk because of a serogroup A, C, W, or Y meningococcal disease outbreak
- People with HIV
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called "persistent complement component deficiency"
- Anyone taking a type of drug called a complement inhibitor, such as eculizumab (also called Soliris®) or ravulizumab (also called Ultomiris®)
- Microbiologists who routinely work with isolates of *N. meningitidis*
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa
- College freshmen living in residence halls
- U.S. military recruits

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of meningococcal ACWY vaccine, or has any severe, life threatening allergies.**

In some cases, your health care provider may decide to postpone meningococcal ACWY vaccination to a future visit.

Not much is known about the risks of this vaccine for a pregnant woman or breastfeeding mother. However, pregnancy or breastfeeding are not reasons to avoid meningococcal ACWY vaccination. A pregnant or breastfeeding woman should be vaccinated if otherwise indicated.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting meningococcal ACWY vaccine.

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- Redness or soreness where the shot is given can happen after meningococcal ACWY vaccine.
- A small percentage of people who receive meningococcal ACWY vaccine experience muscle or joint pains.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call 1 800 822 7967. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

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The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call 1-800-338-2382 to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC's www.cdc.gov/vaccines

Vaccine Information Statement (Interim)

Meningococcal ACWY Vaccines

Office use only

8/15/2019 | 42 U.S.C. § 300aa-26

VACCINE INFORMATION STATEMENT

Meningococcal B Vaccine:
What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Meningococcal B vaccine can help protect against meningococcal disease caused by serogroup B. A different meningococcal vaccine is available that can help protect against serogroups A, C, W, and Y.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

Anyone can get meningococcal disease but certain people are at increased risk, including:

- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of *N. meningitidis*, the bacteria that cause meningococcal disease
- People at risk because of an outbreak in their community

2 Meningococcal B vaccine

For best protection, more than 1 dose of a meningococcal B vaccine is needed. There are two meningococcal B vaccines available. The same vaccine must be used for all doses.

Meningococcal B vaccines are recommended for people 10 years or older who are at increased risk for serogroup B meningococcal disease, including:

- People at risk because of a serogroup B meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called "persistent complement component deficiency"
- Anyone taking a type of drug called a complement inhibitor, such as eculizumab (also called Soliris®) or ravulizumab (also called Ultomiris®)
- Microbiologists who routinely work with isolates of *N. meningitidis*

These vaccines may also be given to anyone 16 through 23 years old to provide short term protection against most strains of serogroup B meningococcal disease. 16 through 18 years are the preferred ages for vaccination.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of meningococcal B vaccine, or has any severe, life-threatening allergies.**
- **Is pregnant or breastfeeding.**

In some cases, your health care provider may decide to postpone meningococcal B vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting meningococcal B vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Soreness, redness, or swelling where the shot is given, tiredness, fatigue, headache, muscle or joint pain, fever, chills, nausea, or diarrhea can happen after meningococcal B vaccine. Some of these reactions occur in more than half of the people who receive the vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)

Meningococcal B Vaccine

Office use only

8/15/2019 | 42 U.S.C. § 300aa-26

HPV (Human Papillomavirus) Vaccine: *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

HPV (Human papillomavirus) vaccine can prevent infection with some types of human papillomavirus.

HPV infections can cause certain types of cancers including:

- cervical, vaginal and vulvar cancers in women,
- penile cancer in men, and
- anal cancers in both men and women.

HPV vaccine prevents infection from the HPV types that cause over 90% of these cancers.

HPV is spread through intimate skin-to-skin or sexual contact. HPV infections are so common that nearly all men and women will get at least one type of HPV at some time in their lives.

Most HPV infections go away by themselves within 2 years. But sometimes HPV infections will last longer and can cause cancers later in life.

2 HPV vaccine

HPV vaccine is routinely recommended for adolescents at 11 or 12 years of age to ensure they are protected before they are exposed to the virus. HPV vaccine may be given beginning at age 9 years, and as late as age 45 years.

Most people older than 26 years will not benefit from HPV vaccination. Talk with your health care provider if you want more information.

Most children who get the first dose before 15 years of age need 2 doses of HPV vaccine. Anyone who gets the first dose on or after 15 years of age, and younger people with certain immunocompromising conditions, need 3 doses. Your health care provider can give you more information.

HPV vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of HPV vaccine, or has any severe, life-threatening allergies.**
- Is pregnant.

In some cases, your health care provider may decide to postpone HPV vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting HPV vaccine.

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- Soreness, redness, or swelling where the shot is given can happen after HPV vaccine.
- Fever or headache can happen after HPV vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

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Revised: 2/18/2008