Lisa P. Allardice MD, F.A.A.P.
Mindy Scheible, NP-C
Diana Hess, CPNP
Carlie Frederick, APRN-BC

Pediatric Associates of LaGrange, P.C.

Today's Date: _____

P

Patient First Name: ☐ Middle Name: ☐ Last Name:

Mark the name patient goes by

Patient SSN: Patient DOB: Sex: M F

Bill Payer: Patient Lives With:

Address: Address:

City: State: Zip: City: State: Zip:

Mother's Cell Phone: - - Mother's Work Phone: - - Home Phone: - -

Father's Cell Phone: - - Father's Work Phone: - - Alt. Phone: - -

A

Mother's Name: Maiden Name: Mother's DOB:

Mother's Employer: Mother's SSN:

Father's Name: Father's SSN: Father's DOB:

Father's Employer:

Primary Insurance: ☐ Dad's Insurance ☐ Mom's Insurance ☐ Other:

Secondary Insurance: ☐ Dad's Insurance ☐ Mom's Insurance ☐ Other:

L

Number of people living in child's household Mother in Household: Y ☐ N ☐ Father in Household: Y ☐ N ☐

Sibling: Age: Healthy: Y ☐ N ☐

Sibling: Age: Healthy: Y ☐ N ☐

Sibling: Age: Healthy: Y ☐ N ☐

Sibling: Age: Healthy: Y ☐ N ☐

S

Persons Allowed to bring child to office visits for treatment	Relationship to patient

PATIENT MEDICAL HISTORY

PATIENT NAME: _____

Please circle if your child has had any of the following:

Bronchiolitis	Kidney Disease	Blackout Spells	Congenital Heart Disease	Behavior Problems
Bronchitis	Kidney Infections	Brain Disease or Injury	Neurofibromatosis	Eye Problems
Persistent Cough	Problems Urinating	Cerebral Shunt	Tuberous Sclerosis	Skin Problems
Wheezing	Urinary Tract Infections	Headaches	Chicken Pox	Immune Problems
Whooping Cough	Urologic Malformations	Seizures	Mumps	Thyroid Problems
Allergies	Constipation	Staring Spells	Measles	Sleep Problems
Hay Fever	Diarrhea	Broken Bones	German Measles	Bleeding Problems
Sinusitis	Excess Weight Gain	Joint Problems	Malignancy or Bone	Eating Problems
Scarlet Fever	Excess Weight Loss	High Blood Pressure	marrow Transplant	Prematurity
Strep Throat	Frequent Vomiting	Treatment with medicine	Solid Organ Transplant	
Tonsillitis	Soiling Pants	known to raise blood	Poisoning	
Bed Wetting	Stomach Ache	pressure	Meningitis	

Please specify any allergies your child has had in the past: _____

Please list any medical problems, surgeries,specialists: _____

Please list all medications currently taken: _____

Hospitalizations: _____

Circle if your child had any of the following with baby shots (immunizations): High Fever, Seizure, Leg Swelling, Uncontrollable Screaming, Other _____

Pregnancy, labor, delivery and nursery: Was your pregnancy planned? Yes No

Circle if you had any of the following during pregnancy:

C-Section	Labor longer than 1 day	Hepatitis B or C	Other pain medicines
Reason for C-Section	Early labor	Syphillis	Kidney infections
_____	Vacuum	Gonorrhea	Other infections
Spinal/Anesthesia	Forceps	High blood pressure	Medicines other than
Infection or fever during labor	Group B Strep	Alcohol or drug abuse	prenatal vitamins
Water leaking > 1 day	HIV	Cigarette use	Cigarette Exposure

Circle it the baby had any of the following problems:

Problem right after birth	Infection	Jaundice	Longer hosp stay than you
Breathing problems	Low sugar	IV or IV antibiotics	Low blood count or anemia
Feeding problems	Heart murmur	ICU	Tube, bag or mask to breathe

What was the child's birth weight? _____ What was the child's Apgar scores? _____
Was the baby full term? If not, how many weeks early? _____ If child stayed in the ICU, where and how long? _____Problems while in ICU? _____
Any signs or symptoms of maternal/paternal depression since child's birth? Y/N Explain: _____

Family History: ***Circle in anyone in your family has any of the following:***

Y/N High cholesterol	Y/N Gallbladder disease	Y/N Seizures	Y/N Eye problems	Y/N Birth defects
Y/N High blood pressure	Y/N Hepatitis B,C	Y/N Migraines	Y/N Deafness	Y/N Cancer
Y/N Rheumatic Fever	Y/N Thyroid disease	Y/N Asthma	Y/N Allergies	Y/N Early death
Y/N Kidney stones	Y/N Diabetes	Y/N Cystic Fibrosis	Y/N Eczema	Y/N Mental disease
Y/N Congenital kidney disease	Y/N Overweight	Y/N TB (Tuberculosis)	Y/N Skin problems	Y/N Mental retardation
Y/N Kidney disease	Y/N Excessive weight gain	Y/N Abnormal fingers or toes	Y/N Cleft lip or palate	Y/N Behavior problems
Y/N Ulcers	Y/N Height less than 5' 0"	Y/N Joint disease	Y/N Bleeding problems	Y/N Learning problems
Y/N Bowel disease (Ileitis)	Y/N Height greater than 6'4"	Y/N Crippling arthritis	Y/N Leukemia	Y/N Reading problems
Y/N Liver problems	Y/N Immune problems	Y/N Sickle cell disease	Y/N Abnormal teeth	Y/N Hyperactivity/ADD/ADHD
Y/N Alcohol problem	Y/N Stroke	Y/N Blindness	Y/N Down's Syndrome	Other_____

Y/N Heart Attack (man less than 40 years/ woman less than 50 years)

Person Completing Form_____Date _____

PEDIATRIC ASSOCIATES OF LAGRANGE, P.C.
LISA P. ALLARDICE, M.D., F.A.A.P.
DIANA L. HESS, CPNP

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Associates of LaGrange, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Associates of LaGrange's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Associates of LaGrange reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric Associates of LaGrange's Privacy Officer at 205 Calumet Center Road, LaGrange, GA, 30241.

With my consent, Pediatric Associates of LaGrange may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatric Associates of LaGrange may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Pediatric Associates of LaGrange may e-mail and/or text to me appointment reminders and patient statements. I have the right to request that Pediatric Associates of LaGrange restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting Pediatric Associates of LaGrange's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatric Associates of LaGrange may decline to provide treatment to me.

I authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Pediatric Associates of LaGrange, P.C., for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Parent or Legal Guardian Date

_____

Print Name of Parent or Legal Guardian

_____

Print Patient's Name

Patient Name: _____

Cholesterol Risk Assessment Questionnaire

1. Have your child's parents or grandparents been diagnosed with high cholesterol at less than 55 years of age? Yes No _____
2. Have your child's parents or grandparents ever had a heart attack At less than 55 years of age? Yes No _____
3. Does your child smoke? Yes No _____
4. Have your child's parents or grandparents ever been diagnosed With heart disease, stroke or blood clot in the legs at less than 55 years of age? Yes No _____
5. Has your child ever had an elevated blood pressure? Yes No _____
6. Have your child's parents or grandparents ever had any heart surgery (angioplasty or bypass surgery) at less than 55 years of age? Yes No _____

Parent Signature _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

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☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

Patient Name:_____

Tuberculosis (TB) Risk Assessment

Circle Yes or No

			*If Yes, please explain
1. Is the child in close contact to a person with active TB disease?*	Yes	No	_____
2. Does the child have or is at risk to have HIV?	Yes	No	_____
3. Was the child or the child's parent born outside the US?	Yes	No	_____
4. Is the child exposed to a person in jail or a person who has been in jail in the past five years?	Yes	No	_____
5. Is the child exposed to a person who has HIV, who is homeless or who lives in nursing home or another group home?	Yes	No	_____
6. Is the child exposed to drug users or migrant farm workers?	Yes	No	_____
7. Does the child have a health problem that lowers the immune system?	Yes	No	_____
8. Does the child live in a community that has a high risk for TB?	Yes	No	_____
9. Has the child traveled to or had any visitors from any foreign country since the last visit?	Yes	No	_____
10. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest x-ray?*	Yes	No	_____

*** Call the Health Department**

Vision Risk Assessment Questionnaire

Circle Yes or No

			*If Yes, please explain
1. Has anyone in your child's family been diagnosed with congenital cateracts, retinoblastoma, metabolic disease, or ocular abnormalities?	Yes	No	_____
2. Has anyone in your child's family been diagnosed with amblyopia (blurred vision) or strabismus (lazy eye)?	Yes	No	_____
3. Has anyone in your child's family been diagnosed with epiphoria (excessive watery eyes), photophobia (light sensitivity), ptosis (drooping of the upper eyelid), or anisocoria (unequal pupil size)?	Yes	No	_____
4. Has anyone in your child's family had glaucoma, eye surgery, or glasses	Yes	No	_____
5. Do your child's eyes appear unusual?	Yes	No	_____
6. Does your child seem not to see well?	Yes	No	_____
7. Does your child exhibit difficulty with near or distance vision?	Yes	No	_____
8. Do your child's eyes appear not to be straight?	Yes	No	_____
9. Do your child's eyelids droop or does one eyelid tend to close?	Yes	No	_____
10. Has your child ever had an eye injury?	Yes	No	_____

Parent Signature _____ Date _____

Please check the box and sign if there have been no changes to the above answers since the last checkup.

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

Patient Name: _____

Lead Risk Assessment Questionnaire

Circle Yes or No

			*If Yes, please explain
1. Does your child live in or often visit a house that may have been built before 1978?	Yes	No	_____
2. Does your child live in or often visit a house that is being remodeled or is having paint removed?	Yes	No	_____
3. Does your child live with or often visit another child that has an elevated blood lead level?	Yes	No	_____
4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses it?	Yes	No	_____
5. Does your child chew on or eat any non-food items like paint chips or dirt?	Yes	No	_____
6. Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead?	Yes	No	_____
7. Does your child receive medicines such as *greta, azarcon,kohl or pay-loo-ah*?	Yes	No	_____

Risk Factors for Hearing Loss

1. Parent or caregiver concern regarding hearing, speech, language, or developmental delay	Yes	No
2. Family history of permanent childhood hearing loss	Yes	No
3. NICU stay greater than five days, ECMO, ototoxic medications, loop diuretics, exchange transfusion	Yes	No
4. In utero infections such as CMV, herpes, rubella, syphilis, Toxoplasmosis	Yes	No
5. Craniofacial anomalies, especially involving the ear and temporal bone	Yes	No
6. Stigmata of syndromes known to cause hearing loss, Eustachian tube dysfunction	Yes	No
7. Syndromes associated with hearing loss or progressive or late-onset hearing loss	Yes	No
8. Neurodegenerative disorders or sensory motor neuropathies	Yes	No
9. Postnatal infections associated with sensorineural hearing loss including bacterial meningitis	Yes	No
10. Head trauma	Yes	No
11. Chemotherapy	Yes	No
12. Recurrent or persistent ear infection for at least 3 months	Yes	No

Parent Signature _____ Date _____

Please check the box and sign if there have been no changes to the above answers since the last checkup.

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

Patient Name: _____

Bright Futures Adolescent Supplemental Questionnaire—Older Child/Younger Adolescent Visits

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

Your Name _____ Today's Date _____

Your Age _____ Your Sex (circle one): M F Your Grade (in school) _____

Your Growing and Changing Body: Physical Growth and Development

1.	Do you live in your parents' home?	Yes	Sometimes	No
2.	Do you receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, or other healer)?	No		Yes
3.	Do you brush your teeth twice a day?	Yes		No
4.	Do you floss once a day?	Yes		No
5.	Have you seen a dentist in the past year?	Yes		No
6.	Do you eat 5 or more helpings of fruits and vegetables each day?	Yes		No
7.	Do you drink milk and eat yogurt, cheese, or other calcium-rich foods (such as dark-green leafy vegetables, or calcium-fortified orange juice or cereal) at least 3 times each day?	Yes		No
8.	Do you eat more than 1 fast food meal per week?	No	Sometimes	Yes
9.	Do you participate in any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?	Yes		No
10.	Do you drink more than 1 soda or juice drink each day?	No		Yes
11.	Do you watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	No		Yes
12.	Do you have any concerns or questions about the size or shape of your body, or physical appearance?	No		Yes
13.	Do you have a problem with your weight (such as underweight, overweight, anorexia, or bulimia)?	No		Yes
14.	Are you on a diet to lose weight?	No		Yes
15.	Do you eat meals together as a family?	Yes		No
16.	Have you talked about body changes and puberty with your parents?	Yes		No
17.	Do you have a TV in your bedroom?	No		Yes
18.	Have you talked to your parents about waiting to have sex?	Yes		No
19.	For females: Have you gotten your period?	Yes		No
20.	If yes, are you having any problems with or do you have any questions about your period?	No	Sometimes	Yes

School and Friends: Social and Academic Competence

21.	Do you go to school?	Yes		No
22.	Are you having any problems in school? Circle all that apply: grades worse than last year failing grade homework suspension this year fighting missing school other _____	No	Sometimes	Yes
23.	Is doing well in school important to you?	Yes		No
24.	Do your parents know your friends and their families?	Yes		No
25.	Do you try to see things from another person's point of view?	Yes		No
26.	Do you try to think through solutions by yourself?	Yes		No

Violence and Injuries: Violence and Injury Prevention

27.	Do you always wear a seat belt when riding in a car, truck, or van?	Yes	Sometimes	No
28.	Do you ever carry a gun (even to protect yourself) or have access to a gun at home or in places where you spend time?	No	Sometimes	Yes
29.	Do you wear a helmet when you in-line skate, skateboard, bicycle, ski, or snowboard?	Yes	Sometimes	No
30.	Is there someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?	No		Yes
31.	Do you have a person you can call for a ride if you're feeling unsafe with someone?	Yes		No

How You Are Feeling: Emotional Well-being

32.	Even with usual ups and downs, do you feel you enjoy life?	Yes		No
33.	Do your parents praise you when you do something good or learn something new?	Yes		No
34.	Do you spend time talking with your parents every day?	Yes		No
35.	Do you clearly discuss with your parents their rules and how you should act?	Yes		No
36.	Do you worry a lot or feel overly stressed out?	No	Sometimes	Yes
37.	When you are angry, do you do violent things?	No		Yes
38.	Do you continue to remember or think about an unpleasant experience that happened in the past?	No		Yes

continued on page 3

Feeling Happy: Emotional Well-being *continued from page 2*

39.	Do you do things as a family?	Yes		No
40.	During the past few weeks have you often felt sad or down, had difficulty sleeping, or frequently felt irritable or as though you have nothing to look forward to?	No		Yes
41.	Do you talk with your parents about relationships and sex?	Yes		No
42.	Do you talk with your parents about alcohol and drugs?	Yes		No
43.	Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself?	No		Yes

Healthy Behavior Choices: Risk Reduction

44.	Does anyone you live with smoke cigarettes or cigars or chew tobacco?	No	Sometimes	Yes

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.

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 health care 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 website at **www.cdc.gov/vaccines**

VACCINE INFORMATION STATEMENT

Tdap Vaccine

What You Need to Know

(Tetanus, Diphtheria and Pertussis)

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?

Tetanus, diphtheria and **pertussis** are very serious diseases. Tdap vaccine can protect us from these diseases. And, Tdap vaccine given to pregnant women can protect newborn babies against pertussis..

TETANUS (Lockjaw) is rare in the United States today. It causes painful muscle tightening and stiffness, usually all over the body.

- It can lead to tightening of muscles in the head and neck so you can't open your mouth, swallow, or sometimes even breathe. Tetanus kills about 1 out of 10 people who are infected even after receiving the best medical care.

DIPHTHERIA is also rare in the United States today. It can cause a thick coating to form in the back of the throat.

- It can lead to breathing problems, heart failure, paralysis, and death.

PERTUSSIS (Whooping Cough) causes severe coughing spells, which can cause difficulty breathing, vomiting and disturbed sleep.

- It can also lead to weight loss, incontinence, and rib fractures. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications, which could include pneumonia or death.

These diseases are caused by bacteria. Diphtheria and pertussis are spread from person to person through secretions from coughing or sneezing. Tetanus enters the body through cuts, scratches, or wounds.

Before vaccines, as many as 200,000 cases of diphtheria, 200,000 cases of pertussis, and hundreds of cases of tetanus, were reported in the United States each year. Since vaccination began, reports of cases for tetanus and diphtheria have dropped by about 99% and for pertussis by about 80%.

2 Tdap vaccine

Tdap vaccine can protect adolescents and adults from tetanus, diphtheria, and pertussis. One dose of Tdap is routinely given at age 11 or 12. People who did *not* get Tdap at that age should get it as soon as possible.

Tdap is especially important for healthcare professionals and anyone having close contact with a baby younger than 12 months.

Pregnant women should get a dose of Tdap during **every pregnancy**, to protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

Another vaccine, called Td, protects against tetanus and diphtheria, but not pertussis. A Td booster should be given every 10 years. Tdap may be given as one of these boosters if you have never gotten Tdap before. Tdap may also be given after a severe cut or burn to prevent tetanus infection.

Your doctor or the person giving you the vaccine can give you more information.

Tdap may safely be given at the same time as other vaccines.

3 Some people should not get this vaccine

- A person who has ever had a life-threatening allergic reaction after a previous dose of any diphtheria, tetanus or pertussis containing vaccine, OR has a severe allergy to any part of this vaccine, should not get Tdap vaccine. Tell the person giving the vaccine about any severe allergies.
- Anyone who had coma or long repeated seizures within 7 days after a childhood dose of DTP or DTaP, or a previous dose of Tdap, should not get Tdap, unless a cause other than the vaccine was found. They can still get Td.
- Talk to your doctor if you:
  - have seizures or another nervous system problem,
  - had severe pain or swelling after any vaccine containing diphtheria, tetanus or pertussis,
  - ever had a condition called Guillain-Barré Syndrome (GBS),
  - aren't feeling well on the day the shot is scheduled.

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

4 Risks

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own. Serious reactions are also possible but are rare.

Most people who get Tdap vaccine do not have any problems with it.

Mild problems following Tdap
(Did not interfere with activities)

- Pain where the shot was given (about 3 in 4 adolescents or 2 in 3 adults)
- Redness or swelling where the shot was given (about 1 person in 5)
- Mild fever of at least 100.4°F (up to about 1 in 25 adolescents or 1 in 100 adults)
- Headache (about 3 or 4 people in 10)
- Tiredness (about 1 person in 3 or 4)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 in 4 adolescents or 1 in 10 adults)
- Chills, sore joints (about 1 person in 10)
- Body aches (about 1 person in 3 or 4)
- Rash, swollen glands (uncommon)

Moderate problems following Tdap
(Interfered with activities, but did not require medical attention)

- Pain where the shot was given (up to 1 in 5 or 6)
- Redness or swelling where the shot was given (up to about 1 in 16 adolescents or 1 in 12 adults)
- Fever over 102°F (about 1 in 100 adolescents or 1 in 250 adults)
- Headache (about 1 in 7 adolescents or 1 in 10 adults)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 or 3 people in 100)
- Swelling of the entire arm where the shot was given (up to about 1 in 500).

Severe problems following Tdap
(Unable to perform usual activities; required medical attention)

- Swelling, severe pain, bleeding and redness in the arm where the shot was given (rare).

Problems that could happen after any vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at fewer than 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

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

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.
- Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would usually start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS 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.

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**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your doctor. He or she 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
Tdap Vaccine

2/24/2015

Office Use Only

42 U.S.C. § 300aa-26

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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