VACCINE INFORMATION STATEMENT

1 Why get vaccinated?

Tetanus, diphtheria and pertussis are very serious diseases. Tdap vaccine can protect you from these diseases. And, Tdap vaccine provides protection for pregnant women to protect newborn babies from tetanus.

The Tdap vaccine is recommended for

• Adults age 18 years and older
• Women of childbearing age

The Tdap vaccine is not recommended for

• Children under 12 years of age
• Pregnancy

The Tdap vaccine is not recommended for pregnant women.

2 Tdap vaccine

Tdap vaccine can protect adolescents and adults from tetanus, diphtheria, and pertussis. One dose of Tdap vaccine is recommended at age 11 or 12 years. People who did not get Tdap at age 11 or 12 years may get it as soon as possible.

Tdap is especially important for healthcare professionals and anyone having close contact with a baby or young child.

Pregnant women should get a dose of Tdap during every pregnancy. Tdap vaccine can provide immunity to the baby. If immunity is lost for any reason, a tetanus and diphtheria booster shot is recommended for children and adults.

3 Some people should not get this vaccine

• A person who has ever had a life-threatening allergic reaction after a previous dose of Tdap vaccine, or a previous dose of DTaP vaccine

• A person who has ever had a severe allergy, such as anaphylaxis, to Tdap vaccine

• A person who has ever had a severe allergic reaction to any other ingredients in this vaccine

4 Risks

Some people may have the following reactions:

• Fever

• Pain at the site of injection

• Redness or swelling at the site of injection

• Localized pain or fever within 24 to 48 hours after injection

• Adverse reactions are very rare

5 What to do if there is a serious reaction?

• If there is a serious reaction, call or contact your healthcare provider as soon as possible.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (NVICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

• Tdap vaccine

Vaccine Information Statement

Meningococcal ACWY Vaccines

Two doses of MenACWY are recommended for children 11 through 18 years of age. The second dose is recommended at 16 years of age. Ask your healthcare provider for more information.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

• If you have ever had a life-threatening allergic reaction after a previous dose of meningococcal ACWY vaccine

• If you have ever had a severe allergic reaction to any other ingredients in this vaccine

4 Risks of a vaccine reaction

• Withholding vaccines, including vaccines, there is a chance of side effects. These are usually mild and do not last long. Serious reactions are very rare.

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Vaccine Consent Form

Please select the vaccine(s) you consent for your child to receive:

- Tdap
- MCV

School Name: __________________________

Please complete all of the information below - Please print using ink (Incomplete forms will not be accepted)

First Name __________________________
Last Name __________________________
Date of Birth (mm/dd/yr) ______/____/____
Age ______

Home Phone # ______-____
Cell Phone # ______-____

City __________________________ Zip Code ______
State __________________________

Gender: Male _____ Female _____

Mother’s Maiden Name: __________________________

Student Race: (Circle one)  African American / Black ______  White ______ Alaskan / Native American ______
Asian Hawaiian / Pacific Islander ______ Other ______

Ethnicity: Non-Hispanic or Hispanic ______

Has your child ever had a life threatening reaction(s) after a previous dose of any diphtheria, tetanus or pertussis containing vaccine? YES ____ NO ____

Has your child ever had a life threatening reaction(s) after a previous dose of meningococcal ACWY vaccine? YES ____ NO ____

Has your child ever had a condition called Guillain Barré Syndrome (GBS)? YES ____ NO ____

Does your child have a blood disorder such as hemophilia? YES ____ NO ____

Has your child ever had seizures or another nervous system problem? YES ____ NO ____

If you have any health questions, please contact your child’s pediatrician or call us at 205-609-0268 to speak to a representative.

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine’s success. I hereby release the school system, HNH Immunizations, Inc. & subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes and your privacy will be protected.

Signature of Parent/Guardian __________________________
Printed Name of Parent/Guardian __________________________
Date ____________

Health Heroes of Ohio, Inc
326 Prairie St. North
Union Springs, AL 36089
AL@healthherouusa.com
205-609-0268

IS CDC 02/24/2015 ADACEL TDAP VACCINE 0.5ML
LOT Number: ______/____/____
RN # ______/____/____

VIS CDC 03/31/2016 MENACTRA MENINGOCOCCAL ACYW 0.5ML
LOT Number: ______/____/____
RN # ______/____/____

Area for official administration use only

Healthcare billing laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential. Please fill out the following questions pertaining to your child’s health insurance:

Parent / Guardian Information

First Name __________________________
Last Name __________________________
Relationship to Patient __________________________

Required Insurance Information (must check an appropriate box)

MEDICAID & MANAGED CARE ORGANIZATIONS

BUCKEYE CARE SOURCE MOLINA PARAMOUNT ADVANTAGE UHC COMMUNITY PLAN STRAIGHT MEDICAID OTHER: (PLEASE SPECIFY NAME) ______

MEMBER ID# ______
MMIS# (PATIENT’S MEDICAID #) ______
NOTE: THIS IS THE ONLY # REQUIRED FOR BUCKEYE PATIENTS

PRIVATE INSURANCE COMPANIES

AETNA BCBS CIGNA CORE SOURCE HUMANA MEDICAL MUTUAL TRI-CARE UHC OTHER: (PLEASE SPECIFY NAME) ______

CARDHOLDER’S FIRST NAME __________________________
CARDHOLDER’S LAST NAME __________________________
CARDHOLDER’S DATE OF BIRTH ___/____/____

Identification / Member ID / Enrollee ID # (include alpha prefix, if shown on card) ______
Payer ID # (if noted on card) ______

Vaccination & Health-Related Questions

1. Has your child ever had a life threatening reaction(s) after a previous dose of any diphtheria, tetanus or pertussis containing vaccine? YES ____ NO ____

2. Has your child ever had a life-threatening allergic reaction after a previous dose of meningococcal ACWY vaccine? YES ____ NO ____

3. Has your child ever had a condition called Guillain Barré Syndrome (GBS)? YES ____ NO ____

4. Does your child have a blood disorder such as hemophilia? YES ____ NO ____

5. Has your child ever had seizures or another nervous system problem? YES ____ NO ____

STOP
This form is only for those who need vaccinations for your child to be vaccinated.

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