



## Crawford County Health Department

202 N. Christopher Boulevard  
Robinson, Illinois 62454

Phone: 618-544-8798  
Fax: 618-544-9398  
Website: [www.cchd.net](http://www.cchd.net)

March 20, 2024

Dear Parents/Legal Guardians:

We are pleased to offer your 5<sup>th</sup> grade students the opportunity to have their required 6<sup>th</sup> grade vaccines completed at school this year. The child must be **eleven years old** by the date listed below to be eligible for their vaccines.

### Required Vaccines for 6<sup>th</sup> Grade Include:

- Meningitis (MCV 4)
- Tdap

### Recommended Vaccines Include:

- Human Papilloma Virus (HPV)
- Hepatitis A

Attached to this letter you will find the required forms to allow your student to receive their vaccines on **Wednesday, April 17th, 2024 at your child's school.** All students must have properly completed forms in order to receive these vaccinations. *All forms must be completed in ink by the parent or guardian.*

- Please read the attached Tdap and Meningococcal information sheets (and optional vaccine information sheets) before completing the attached **“Consent Form”**. Please complete the top portion with your child's information and answer questions 1-16. **Please pay special attention to question #15. If it is answered “NO” your child will not receive vaccinations.** The required vaccines have been marked at the bottom of the form. Recommended vaccines for 6<sup>th</sup> graders are boxed and need to be marked by the parent if they would like their child to receive the vaccine (please see Recommended Vaccine Fact Sheet or call CCHD for more information). You do not need to complete the back-side of this form.
- Please complete the top portion of the **“Billing Form”** with the child's information at the top, insurance information in the next section, sign, and date. We accept Medicaid and most insurances. Be sure to include the name of the insurance company, Member ID, and Group number. If you have any questions regarding your insurance, or if your child does not have insurance, please contact our office at 618-544-8798.
- The **“Patient Eligibility Screening Form”** must be completed, as this is a legal requirement of the Vaccines for Children Program. Please complete questions 1-5. On Question #5, please mark Columns **B, C, F** (if applicable) as well as the **Date** Column.
- Please acknowledge you received the information sheet regarding HIPAA by completing the **“Acknowledgment of Notice of Privacy Practices”** with your child's printed name and date of birth, your signature, and date.

Please return all paperwork listed above for your child to school by **Tuesday, April 9, 2024** to take advantage of these services! If any information you filled out changes before the date of vaccination or you have any questions, please contact Jenna Thompson, RN, Nursing Supervisor or the nursing staff at Crawford County Health Department at 618-544-8798.

Thank you!

*“Promoting Health, Preventing Illness, and Protecting our Environment.”*

CRAWFORD COUNTY HEALTH DEPARTMENT  
202 NORTH CHRISTOPHER BLVD, ROBINSON, IL 62454 (618) 544-8798

*Consent Form*

**CHILD'S INFORMATION (PLEASE PRINT):**

|                 |              |       |            |      |
|-----------------|--------------|-------|------------|------|
| LAST NAME:      | FIRST:       | MI:   | BIRTHDATE: | AGE: |
| STREET ADDRESS: |              | CITY: | ST:        | ZIP: |
| COUNTY:         | HOME NUMBER: |       | PHYSICIAN: |      |

- |     |   |   |   |     |
|-----|---|---|---|-----|
| 1.  | Is the client sick (with an illness other than a cold)?   | Y | N |     |
| 2.  | Has the client had a fever of 100 degrees or greater during the last 24 hours?  | Y | N |     |
| 3.  | Has the client received an immunization or TB skin test within the last 30 days?  | Y | N |     |
| 4.  | Does the client have a disease that lowers the body's resistance to infections, such as leukemia, lymphoma, generalized malignancy or AIDS?   | Y | N |     |
| 5.  | Is the client being treated with drugs/medication, such as cortisone or prednisone, chemotherapy, or radiation, that lower the body's resistance to infections?   | Y | N |     |
| 6.  | Does the client live in the same household with anyone who has a condition that lowers the body's resistance to infection?  | Y | N |     |
| 7.  | Is the client allergic to an antibiotic called neomycin, Streptomycin, Polymyxin B, eggs, gelatin, alum or common baker's yeast (swelling of the mouth or throat, difficulty in breathing, shock)?  | Y | N |     |
| 8.  | Has the client had a blood or plasma transfusion or received immune globulin (an important injection for preventing infection from certain diseases) within the last five months?   | Y | N |     |
| 9.  | Has the client ever had convulsions or other neurologic problems?   | Y | N |     |
| 10. | Has the client been diagnosed as having Multiple Sclerosis?   | Y | N |     |
| 11. | Is the client pregnant or planning pregnancy within the next 3 months?  | Y | N | N/A |
| 12. | Has the client ever had a reaction to a previous immunization such as: fever greater than 105 degrees, convulsions, total collapse or shock, a high-pitched cry or screaming episode of 3 hours or more, severe itching rash or anaphylactic allergic reaction? | Y | N |     |
| 13. | Has the client ever had a serious reaction to a product containing thimerosal (mercury derivative) or latex?  | Y | N |     |
| 14. | I have been advised, the client should avoid aspirin products for six weeks after receiving the Varicella (Chickenpox) or Proquad (MMRV) vaccine.   | Y | N | N/A |
| 15. | I have read and understand the possible side effects described in the "Vaccine Information Statement" that can be caused by the vaccine.  | Y | N |     |
| 16. | I understand that my adolescent/teenager should be monitored for 15 min. by CCHD staff after receiving vaccine.   | Y | N |     |

\* If the answer to any of the questions above is "Yes", except for 14, 15 and 16, consult with the nurse before receiving immunizations.

Tdap   
  MCV 4   
 
 HPV   
  HEP A

**I have read, understand and have had the opportunity to ask questions concerning vaccine information. I believe I understand the benefits and risks of the vaccines to be given to the person named above for whom I am authorized to make this request. I hereby give consent to obtain/release immunization records to health-related personnel.**

\_\_\_\_\_  
PARENT OR LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NURSE SIGNATURE

\_\_\_\_\_  
DATE

Revised 12/05/22

VACCINE ADMINISTRATION RECORD-FOR OFFICE USE ONLY

|           | <u>Manufacturer</u> | <u>Lot #</u> | <u>Site</u> | <u>Nurse Initial</u> | <u>Date of VIS</u> |
|-----------|---------------------|--------------|-------------|----------------------|--------------------|
| DTaP      | _____               | _____        | _____       | ___/___              | 08/06/21           |
| Pediarix  | _____               | _____        | _____       | ___/___              | 10/15/21           |
| (DTaP)    |                     |              |             |                      | 08/06/21           |
| (IPV)     |                     |              |             |                      | 08/06/21           |
| (HEP B)   |                     |              |             |                      | 08/15/19           |
| MMRV      | _____               | _____        | _____       | ___/___              | 08/06/21           |
| Kinrix    | _____               | _____        | _____       | ___/___              |                    |
| (DTaP)    |                     |              |             |                      | 08/06/21           |
| (IPV)     |                     |              |             |                      | 08/06/21           |
| HIB       | _____               | _____        | _____       | ___/___              | 08/06/21           |
| HEP A     | _____               | _____        | _____       | ___/___              | 10/15/21           |
| HEP B     | _____               | _____        | _____       | ___/___              | 10/15/21           |
| HPV       | _____               | _____        | _____       | ___/___              | 08/06/21           |
| MMR       | _____               | _____        | _____       | ___/___              | 08/06/21           |
| MCV 4     | _____               | _____        | _____       | ___/___              | 08/06/21           |
| PCV 13    | _____               | _____        | _____       | ___/___              | 02/04/22           |
| IPV       | _____               | _____        | _____       | ___/___              | 08/06/21           |
| Rotavirus | _____               | _____        | _____       | ___/___              | 10/15/21           |
| Td        | _____               | _____        | _____       | ___/___              | 08/06/21           |
| Tdap      | _____               | _____        | _____       | ___/___              | 08/06/21           |
| Varicella | _____               | _____        | _____       | ___/___              | 08/06/21           |
| Men B     | _____               | _____        | _____       | ___/___              | 08/06/21           |

**Documentation of brief office visit:**

Provided counseling and written information regarding possible minor side effects, pain relief measures, signs of serious reactions and procedure to follow if such should occur.

\_\_\_\_\_  
Nurse Initials      \_\_\_\_\_  
Date Vaccine Admin.      \_\_\_\_\_  
Nurse Initials      \_\_\_\_\_  
Date Vaccine Admin.      \_\_\_\_\_

\_\_\_\_\_  
Date VIS Given

**CRAWFORD COUNTY HEALTH DEPARTMENT**

202 N. Christopher Blvd., Robinson, IL 62454 Phone: 618-544-8798 Fax: 618-544-9398

Provider ID 37-6000668  
NPI# 1013262914

**Client's Name:** \_\_\_\_\_ **Date of Service:** 4/17/24  
 (FIRST) (LAST)  
**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ **Cell Number:** \_\_\_\_\_ **Sex:** Male \_\_\_\_\_ Female \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Parent/Guardian's Name:** \_\_\_\_\_

**Payment Method and/or Bill To: (Check ALL that Apply)**  
 VFC (Use VFC Code & Dx Code Z00.129) Adult = Z00.8  
 Pay at Time of Service  
 Bill To/Address: \_\_\_\_\_  
 Insurance ID/Group #: \_\_\_\_\_ Eligibility Verified   
 Medicaid #: \_\_\_\_\_  
 Medicare #: \_\_\_\_\_

I authorize Crawford County Health Department to enter my personal information into NueMD (billing and scheduling software) and release service related information regarding the above mentioned person to third party payors and/or other health practitioners and to bill for services rendered to me if applicable. I request my payor to pay CCHD directly for services rendered to me. I understand I am responsible for payment in the event my third party payor determines I am ineligible for this benefit.

Signature \_\_\_\_\_ Date \_\_\_\_\_

| ✓ IMMUNIZATIONS                | DX          | CPT         | FEE   |
|--------------------------------|-------------|-------------|-------|
| Covid (Moderna)                | Z23         | 91322       | \$155 |
| Dtap                           | Z23         | 90700       | \$45  |
| Dtap-IPV-Hep B (Pediatrix)     | Z23         | 90723       | \$120 |
| Dtap-IPV (Kinrix)              | Z23         | 90696       | \$80  |
| Hep A Adult                    | Z23         | 90632       | \$105 |
| Hep A Pediatric                | Z23         | 90633       | \$55  |
| Hep B Adult                    | Z23         | 90746       | \$100 |
| Hep B Pediatric                | Z23         | 90744       | \$45  |
| Hib (Pedvax)                   | Z23         | 90647       | \$45  |
| HPV (Gardasil)                 | Z23         | 90651       | \$340 |
| Meningitis (Bexsero)           | Z23         | 90620       | \$270 |
| Meningitis (MCV4)              | Z23         | 90734       | \$190 |
| MMR                            | Z23         | 90707       | \$120 |
| MMRV MMR & Varicella (Proquad) | Z23         | 90710       | \$330 |
| PCV 15 (Prenar 15)             | Z23         | 90671       | \$275 |
| PCV 20                         | Z23         | 90677       | \$320 |
| Pneumonia 23 (Adult)           | Z23         | 90732       | \$150 |
| Polio IPV                      | Z23         | 90713       | \$55  |
| Rabies                         | Z23         | 90675       | \$475 |
| Rotavirus 2 dose (Rotarix)     | Z23         | 90681       | \$175 |
| RSV (Abrysvo)                  | Z23         | 90678       | \$370 |
| Shingles (Shingrix)            | Z23         | 90750       | \$235 |
| Td - Tetanus/Diphtheria        | Z23         | 90714       | \$50  |
| Tdap                           | Z23         | 90715       | \$65  |
| Varicella                      | Z23         | 90716       | \$205 |
| ✓ NURSING SERVICES             | DX          | CPT         | FEE   |
| Blood Pressure Screen / Ref    |             |             |       |
| Breastfeeding Consultations    |             |             |       |
| Brief Office Visit             | Varies      | 99211       | \$25  |
| ASQ-3 / Referral               | Z00.129     | *96110      | \$25  |
| ASQ-SE / Referral              | Z00.129     | *96110      | \$25  |
| Edinburgh - Prenatal           | Z13.89      | H1000       | \$25  |
| Non-Depression Screening       | Z13.89      | 96127       | \$25  |
| Depression Screening-Positive  | Z13.89      | G8431       | \$25  |
| Depression Screening-Negative  | Z13.89      | G8510       | \$25  |
| EPSDT New <1                   | Z00.129     | 99381       | \$165 |
| EPSDT New 1-4                  | Z00.129     | 99382       | \$175 |
| EPSDT Re-eval <1               | Z00.129     | 99391       | \$150 |
| EPSDT Re-eval 1-4              | Z00.129     | 99392       | \$160 |
| Head Lice Check/Recheck        | Z20.89      | 99211       | \$25  |
| Hearing Screening              | Z00.129     | 92551       | \$25  |
| Hearing Screening / Referral   | Z00.129     | 92551       | \$25  |
| OAE Hearing                    | Z00.129     | 92558       | \$20  |
| OAE Rescreen / Referral        | Z00.129     | 92558       | \$20  |
| Home Visit - Infant/Child      |             |             |       |
| Home Visit - Prenatal          |             |             |       |
| Jail Visit                     | _____ Hours | _____ Miles |       |
| School Health                  | _____ Hours | _____ Miles |       |
| Topical Fluoride Varnish       | Z41.8       | D1206       | \$30  |
| Vision Screening / Rescreen    | Z00.129     | 99173       | \$10  |

| ✓ IMMUNIZATION ADMIN                                   | CPT    | FEE   |      |
|--|--------|-------|------|
| Single Uninsured / Admin & Brief Office Visit          | 90471  | \$30  |      |
| Each Additional Uninsured / Admin & Brief Office Visit | 90472  | \$20  |      |
| Single Covid Admin                                     | 90480  | \$30  |      |
| ORAL/INTRANASAL  |        |       |      |
| Single Uninsured / Admin & Brief Office Visit          | 90473  | \$30  |      |
| Each Additional Uninsured / Admin & Brief Office Visit | 90474  | \$20  |      |
| ✓ ENVIRONMENTAL HEALTH                                 | DX     | CPT   | FEE  |
| Water Test Kit   |        |       | \$25 |
| ✓ FLU VACCINATIONS                                     | DX     | CPT   | FEE  |
| Fluad 65 yrs & older (preserve-free prefilled)         | Z23    | 90694 | \$72 |
| Fluarix 6 mos & older (preserve-free prefilled)        | Z23    | 90686 | \$22 |
| ✓ LAB SERVICES   | DX     | CPT   | FEE  |
| Blood Glucose Screening / Ref                          | Z13.1  | 82947 | \$8  |
| Handling/convey spec to Lab                            |        | 99000 | \$15 |
| Hemoglobin (Finger stick)                              | Z13.0  | 85018 | \$5  |
| Lab Draw Fee (Venipuncture)                            | Z11.9  | 36415 | \$30 |
| Lab Test Services                                      |        |       | call |
| Lead Screening Adult                                   | Z13.88 | 83655 | \$45 |
| Lead Screening Child                                   | Z13.88 | 36416 | \$25 |
| Parentage Testing                                      |        |       |      |
| Pregnancy Testing Positive / Negative                  | Z30.09 | 81025 | \$15 |
| 1 step TB Skin Test Read _____ Date Given              | Z11.1  | 86580 | \$15 |
| 2 step TB Skin Test Read _____ Date Given              | Z11.1  | 86580 | \$15 |
| Urine 10 Drug Screening                                | Z00.8  | 80104 | \$45 |

**Total Charges for Services** \$ \_\_\_\_\_

**Co-Pay** \$ \_\_\_\_\_

**BALANCE DUE** \$ \_\_\_\_\_

Cash  Credit/Debit

Check # \_\_\_\_\_

**INFORMATION VERIFIED**

**BY NURSE:** \_\_\_\_\_

**COMMENTS:**



## Pediatric Vaccines Patient Eligibility Screening Record

Beginning 1-14-2023



A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 3 years or longer depending on state law. Eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure that the child's eligibility status has not changed since the last visit. Children who have Medicaid must have their eligibility verified in Medi before vaccinations are administered at each visit. It is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name: \_\_\_\_\_  

Last Name
First Name
MI
  
2. Child's Date of Birth: \_\_\_\_\_
  
3. Parent/Guardian/Individual of Record: \_\_\_\_\_  

Last Name
First Name
MI
  
4. Primary Provider's Name: \_\_\_\_\_  

Last Name
First Name
MI
  
5. To determine if a child (0 through 18 years of age) is eligible to receive publicly funded vaccine, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-E is marked, the child is eligible for blended inventory vaccines. If column F or G is marked the child is not eligible for publicly funded vaccine.*

|      | Eligible for Blended Inventory Vaccine |                           |   |  |   | Not eligible for VFC Vaccine                    |                             |
|------|--|---------------------------|---|--|---|---|-----------------------------|
|      | A                                      | B                         | C                                       | D  | E   | F   | G                           |
| Date | Medicaid Enrolled Title XIX (19) (V02) | No Health Insurance (V03) | American Indian or Alaskan Native (V04) | *Underinsured served by FQHC, RHC or deputized LHD (V05) | **Enrolled in CHIP Title XXI (21) or State Funded (V22) | Has health insurance that covers vaccines (V01) | ***Other underinsured (V01) |
|      |  |                           |   |  |   |   |                             |
|      |  |                           |   |  |   |   |                             |
|      |  |                           |   |  |   |   |                             |
|      |  |                           |   |  |   |   |                             |
|      |  |                           |   |  |   |   |                             |
|      |  |                           |   |  |   |   |                             |
|      |  |                           |   |  |   |   |                             |
|      |  |                           |   |  |   |   |                             |

**Footnotes:**

\* Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.

\*\* Eligible for blended inventory as of 1/14/2023.

\*\*\* Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider.

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# The Crawford County Health Department

## Acknowledgment of Notice of Privacy Practices

My signature below indicates that I have been given an opportunity to read the Notice Of Privacy Practices for the Crawford County Health Department, and to have any questions answered before signing.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

If signed by someone other than the patient, please indicate relationship to patient:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

***FOR OFFICE USE ONLY:***

Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_

If patient or patient's representative refuses to sign this Acknowledgment:

Efforts to Obtain: \_\_\_\_\_

Reason patient refused to sign: \_\_\_\_\_

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# The Crawford County Health Department

## Notice of Privacy Practices

**This Notice of Privacy Practices describes how medical information about you may be used and disclosed; and how you can get access to this information. Please review it carefully.**

**If you have questions about this Notice, please contact our office.**

### **Who Will Follow This Notice**

This “Notice of Privacy Practices” (aka Notice) describes the privacy practices of the Crawford County Health Department (aka Department) and those of:

- Any health care professional authorized to enter information into your medical chart.
- All divisions and units of the Department, and the operations the Department outsources to certain of our business partners, as well as their Business Associates.
- All of our workforce, employed or otherwise.

All these entities, sites and locations follow the terms of this Notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or operations purposes described in this Notice.

### **Our Pledge Regarding Medical Information**

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our facilities. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by us. Your hospital or other physicians may have different policies or notices regarding the use and disclosure of medical information they create.

This Notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights, and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Make available to you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect. This Notice may change, in the manner described below under “Changes to This Notice.”

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The following categories describe different ways that we use and disclose your medical information (also known as Individually Identifiable Health Information (IIHI) and/or Protected Health Information (PHI)). For each category of use or disclosure, we provide examples, but not every use or disclosure in a category is listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, we may forward your records to another specialist to assure that you receive proper care. Also, if you were referred to us by another health care provider, it is likely that we will report back to that provider with information about our diagnosis and plan for treatment.

We may disclose medical information about you to people outside the Department who may be involved in your medical care, such as family members, close friends, clergy or others we use to provide services that are a part of your care. For instance, from time-to-time we may receive calls from concerned family members or close friends to determine if a patient has completed his or her appointment. Unless you have advised us otherwise, in writing, we will let them know your current status with our office. In addition, at some time, it may be necessary for our staff to reach you by telephone in regard to your appointment. Unless otherwise notified by you in writing, we will contact you using numbers you have provided and we may have to leave a voicemail message for you. In certain circumstances, care givers from nursing homes, assisted living centers, etc. will bring a patient to our facility. Often these care givers are exposed to that patient's personal health information.

- **For Payment**

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed to and collected from you, an insurance company or health plan or other third party. For example, we may need to give your health plan specific information about treatment you received at our office so your health plan will pay us or reimburse you for the treatment. In addition, we, or our representatives, may discuss payment issues with family members or others involved in the process of paying for medical treatment you have received. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may have our bills and payment arrangements outsourced to one or more third-party service providers who issue, process and collect bills on our behalf. Each of these is governed by the same health care information disclosure and confidentiality laws that we must follow.

- **For Health Care Operations**

We may use and disclose medical information about you for our Department operations. These uses and disclosures are necessary to run our Department and make sure that all our patients receive quality care. For example, we may use medical information to review our treatment and services, and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technologists, medical students, and other members of our staff for review and learning purposes.

- **Treatment Alternatives**

We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Business Associates**

On occasion the Department may use outside organizations to provide business services. Business Associates that will be exposed to your health information are required to comply with



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all the same HIPAA administrative, physical and technical safeguard requirements that apply to the Department. Also, if the business associate contracts with a third party, they too must comply with all HIPAA rules.

- **As Required By Law**

We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert A Serious Threat To Health Or Safety**

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public, or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Special Situations**

We may also use and disclose medical information about you in the situations described under "Special Situations," below.

### **Other Uses Of Medical Information**

Other uses and disclosures of medical information not covered by this Notice, or the laws that apply to us, will be made only with your written authorization. A form for such authorizations, both those that you request and those that we request, is available from our office. If you give us an authorization, you may later revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. In that case, however, we will be unable to take back any disclosures we have already made with your permission, and we will still be required to retain our records of the care that we provided to you.

### **Special Situations** *(Including but not limited to...)*

#### **Military and Veterans**

If you are a member of the armed forces, we may release medical information about you as required by military command authorities, or in some cases, if needed to determine benefits to the Department of Veterans Affairs.

#### **Public Health Risks**

We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and/or
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law.

#### **Health Oversight Activities**

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

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### **Immunization Reporting**

The Department may disclose proof of immunization to a school where law requires a school to have such information. Written authorization for this disclosure is not required, however, the Department will obtain agreement to this release, which may be oral, from a parent, guardian or other person acting in *loco parentis* for the individual, or from the individual himself or herself, if the individual is an adult or emancipated minor.

### **Outside Use**

It is a violation of Department Policy to use patient PHI for Marketing, Research or to sell PHI in any way. Under no circumstances will the Department engage in these activities.

### **Fundraising**

It is a violation of Department Policy to use patient PHI for fundraising purposes. The Department will not contact patients to conduct fundraising activities using PHI as a source of identification.

### **Lawsuits and Disputes**

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

### **Law Enforcement**

We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

### **Coroners, Medical Examiners and Funeral Directors**

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

### **Decedents**

A decedent's PHI is protected for 50 years after the individual's death. After that point, the information is no longer considered PHI.

### **National Security, Intelligence and Federal Protective Service Activities**

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, and to authorized federal officials where required to provide protection to the President of the United States, other authorized persons or foreign heads of state or conduct special investigations.

### **Inmates**

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official where necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

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## **Your Rights Regarding Medical Information About You**

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**

You have the right to inspect and request a copy of medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

You may request an electronic copy of your PHI that is maintained electronically. The Department will provide an electronic copy in the form requested, if readily producible, or if not, in a readable electronic form and format as agreed by you and the Department.

You must submit any request to inspect and copy your medical records to our staff, in writing. (A form for that request is available from our office.) If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another health care professional chosen by our staff will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

- **Right to Amend**

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our Department. You must submit any request for an amendment to our staff, in writing. (A form for that request is available from our office.) Your written request must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for our Department.
- Is not part of the information which you are permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures**

You have the right to request an “accounting of disclosures.” This is a list of the disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and may include:

- Many routine disclosures for treatment, payment and operations; and
- Disclosures to you.

You must submit any request for an accounting of disclosures to our office, in writing. (A form for that request is available from our office.) Your written request must state a time period, which may not be longer than six years. The first report you request within a 12-month period will be free. For additional reports, we may charge you for the costs of providing the report. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right

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to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a medical service you received. Also, you have the right to designate a personal representative who will then have the ability to access your personal health information, just as you do. You may also ask us to be selective in the way we communicate personal health information to you. For example, you may request that we not contact you by telephone at your office or you may designate a mailing address other than your home. Such requests must be made in writing. (A form for such requests is available from our office.) Please note that we are not required to agree to your requests. However, if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to restrict the disclosure of PHI (for payment or health care operations) to a health plan when you pay out-of-pocket, in full, and request such a restriction. The Department must honor such a request unless otherwise required by law. This restriction does not apply to follow-up visits if they are not paid for in full out of pocket.

You must submit any request for restrictions to our staff, in writing. (A form for each request is available from our office.) Your written request must tell us:

- What information you want to limit;
  - Whether you want to limit our use, disclosure or both; and
  - To whom you want the limits to apply, for example, disclosures to your spouse.
- **Right to a Paper Copy of This Notice**

You may ask us to give you a paper copy of this “Notice of Privacy Practices” at any time by contacting our office.
  - **Right to Receive a Breach Notice**

Should the Department experience an impermissible use or disclosure of PHI and that exposure poses a significant risk of financial, reputational, or other harm to an individual, the Department will provide individual notice to all persons affected by the breach.
  - **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our office. (A form for this purpose is available from our office.) You will not be penalized for filing a complaint.

### **The Crawford County Health Department’s Right to Make Changes to This Notice**

The Department reserves the right to change this Notice. When we do, we may make the changed Notice effective for medical information we already have about you, as well as information we receive in the future. We will post a copy of the current Notice in our facilities. Each Notice will contain on the first page, in the top right-hand corner, its effective date. Also, each time you register at our office for medical services, a copy of the current Notice in effect will be available to you in the waiting area.

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

Many vaccine information statements are available in Spanish and other languages. See [www.immunize.org/vis](http://www.immunize.org/vis)

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://www.immunize.org/vis)

## 1. Why get vaccinated?

Tdap vaccine can prevent **tetanus, diphtheria, and pertussis**.

Diphtheria and pertussis spread from person to person. Tetanus enters the body through cuts or wounds.

- **TETANUS (T)** causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.
- **DIPHTHERIA (D)** can lead to difficulty breathing, heart failure, paralysis, or death.
- **PERTUSSIS (aP)**, also known as “whooping cough,” can cause uncontrollable, violent coughing that makes it hard to breathe, eat, or drink. Pertussis can be extremely serious especially in babies and young children, causing pneumonia, convulsions, brain damage, or death. In teens and adults, it can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

## 2. Tdap vaccine

Tdap is only for children 7 years and older, adolescents, and adults.

**Adolescents** should receive a single dose of Tdap, preferably at age 11 or 12 years.

**Pregnant people** should get a dose of Tdap during every pregnancy, preferably during the early part of the third trimester, to help protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

**Adults** who have never received Tdap should get a dose of Tdap.

Also, **adults should receive a booster dose of either Tdap or Td** (a different vaccine that protects against tetanus and diphtheria but not pertussis) **every 10 years**, or after 5 years in the case of a severe or dirty wound or burn.

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

## 3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria, or pertussis**, or has any **severe, life-threatening allergies**
- Has had a **coma, decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine (DTP, DTaP, or Tdap)**
- Has **seizures or another nervous system problem**
- Has ever had **Guillain-Barré Syndrome** (also called “GBS”)
- Has had **severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diphtheria**

In some cases, your health care provider may decide to postpone Tdap vaccination until 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 Tdap vaccine.

Your health care provider can give you more information.



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

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## 4. Risks of a vaccine reaction

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- Pain, redness, or swelling where the shot was given, mild fever, headache, feeling tired, and nausea, vomiting, diarrhea, or stomachache sometimes happen after Tdap vaccination.

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.

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## 5. What if there is a serious problem?

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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](http://www.vaers.hhs.gov) or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

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## 6. The National Vaccine Injury Compensation Program

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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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation) or call **1-800-338-2382** to learn about the program and about filing a claim.

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## 7. How can I learn more?

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- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at [www.fda.gov/vaccines-blood-biologics/vaccines](http://www.fda.gov/vaccines-blood-biologics/vaccines).
- 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](http://www.cdc.gov/vaccines).



# Meningococcal ACWY Vaccine:

## What You Need to Know

Many vaccine information statements are available in Spanish and other languages. See [www.immunize.org/vis](http://www.immunize.org/vis)

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

Meningococcal disease is rare and has declined in the United States since the 1990s. However, it is a severe disease with a significant risk of death or lasting disabilities in people who get it.

Anyone can get meningococcal disease. 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 years 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 “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 who have not been completely vaccinated with meningococcal ACWY vaccine
- U.S. military recruits



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### 3. Talk with your health care provider

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Tell your vaccination 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 until a future visit.

There is limited information on the risks of this vaccine for pregnant or breastfeeding people, but no safety concerns have been identified. A pregnant or breastfeeding person should be vaccinated if indicated.

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.

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### 4. Risks of a vaccine reaction

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- Redness or soreness where the shot is given can happen after meningococcal ACWY vaccination.
- A small percentage of people who receive meningococcal ACWY vaccine experience muscle pain, headache, or tiredness.

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.

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### 5. What if there is a serious problem?

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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](http://www.vaers.hhs.gov) or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

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### 6. The National Vaccine Injury Compensation Program

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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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation) or call **1-800-338-2382** to learn about the program and about filing a claim.

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### 7. How can I learn more?

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- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at [www.fda.gov/vaccines-blood-biologics/vaccines](http://www.fda.gov/vaccines-blood-biologics/vaccines).
- 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](http://www.cdc.gov/vaccines).





# 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](http://www.immunize.org/vis)

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://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
- anal cancers in both men and women
- cancers of tonsils, base of tongue, and back of throat (oropharyngeal cancer) in both men and women

HPV infections can also cause anogenital warts.

HPV vaccine can prevent over 90% of cancers caused by HPV.

HPV is spread through intimate skin-to-skin or sexual contact. HPV infections are so common that nearly all people will get at least one type of HPV at some time in their lives. Most HPV infections go away on their own 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 vaccination is recommended for everyone through 26 years of age.

HPV vaccine may be given to adults 27 through 45 years of age, based on discussions between the patient and health care provider.

Most children who get the first dose before 15 years of age need 2 doses of HPV vaccine. People who get the first dose at 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 vaccination 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**—HPV vaccine is not recommended until after pregnancy

In some cases, your health care provider may decide to postpone HPV vaccination until 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.



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## 4. Risks of a vaccine reaction

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

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.

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## 5. What if there is a serious problem?

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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](http://www.vaers.hhs.gov) or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

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## 6. The National Vaccine Injury Compensation Program

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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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation) or call **1-800-338-2382** to learn about the program and about filing a claim.

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## 7. How can I learn more?

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- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at [www.fda.gov/vaccines-blood-biologics/vaccines](http://www.fda.gov/vaccines-blood-biologics/vaccines).
- 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](http://www.cdc.gov/vaccines).



# Hepatitis A Vaccine:

## What You Need to Know

Many vaccine information statements are available in Spanish and other languages. See [www.immunize.org/vis](http://www.immunize.org/vis)

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://www.immunize.org/vis)

### 1. Why get vaccinated?

Hepatitis A vaccine can prevent **hepatitis A**.

**Hepatitis A** is a serious liver disease. It is usually spread through close, personal contact with an infected person or when a person unknowingly ingests the virus from objects, food, or drinks that are contaminated by small amounts of stool (poop) from an infected person.

Most adults with hepatitis A have symptoms, including fatigue, low appetite, stomach pain, nausea, and jaundice (yellow skin or eyes, dark urine, light-colored bowel movements). Most children less than 6 years of age do not have symptoms.

A person infected with hepatitis A can transmit the disease to other people even if he or she does not have any symptoms of the disease.

Most people who get hepatitis A feel sick for several weeks, but they usually recover completely and do not have lasting liver damage. In rare cases, hepatitis A can cause liver failure and death; this is more common in people older than 50 years and in people with other liver diseases.

Hepatitis A vaccine has made this disease much less common in the United States. However, outbreaks of hepatitis A among unvaccinated people still happen.

### 2. Hepatitis A vaccine

**Children** need 2 doses of hepatitis A vaccine:

- First dose: 12 through 23 months of age
- Second dose: at least 6 months after the first dose

**Infants 6 through 11 months old** traveling outside the United States when protection against hepatitis A is recommended should receive 1 dose of hepatitis A vaccine. These children should still get 2 additional doses at the recommended ages for long-lasting protection.

**Older children and adolescents** 2 through 18 years of age who were not vaccinated previously should be vaccinated.

**Adults** who were not vaccinated previously and want to be protected against hepatitis A can also get the vaccine.

Hepatitis A vaccine is also recommended for the following people:

- International travelers
- Men who have sexual contact with other men
- People who use injection or non-injection drugs
- People who have occupational risk for infection
- People who anticipate close contact with an international adoptee
- People experiencing homelessness
- People with HIV
- People with chronic liver disease

In addition, a person who has not previously received hepatitis A vaccine and who has direct contact with someone with hepatitis A should get hepatitis A vaccine as soon as possible and within 2 weeks after exposure.

Hepatitis A 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

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### 3. Talk with your health care provider

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Tell your vaccination provider if the person getting the vaccine:

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

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

Pregnant or breastfeeding people should be vaccinated if they are at risk for getting hepatitis A. Pregnancy or breastfeeding are not reasons to avoid hepatitis A vaccination.

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 A vaccine.

Your health care provider can give you more information.

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### 4. Risks of a vaccine reaction

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- Soreness or redness where the shot is given, fever, headache, tiredness, or loss of appetite can happen after hepatitis A vaccination.

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.

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### 5. What if there is a serious problem?

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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](http://www.vaers.hhs.gov) or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

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### 6. The National Vaccine Injury Compensation Program

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### 7. How can I learn more?

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- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at [www.fda.gov/vaccines-blood-biologics/vaccines](http://www.fda.gov/vaccines-blood-biologics/vaccines).
- 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](http://www.cdc.gov/vaccines).



# Don't Wait to Vaccinate

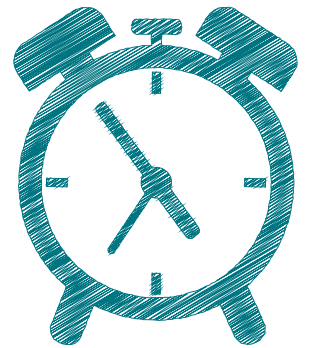


Mission: **HPV** **CANCER FREE**

[cancer.org/hpv](https://cancer.org/hpv)

## DID YOU KNOW...

The American Cancer Society recommends that boys and girls get vaccinated against HPV between the ages of **9 and 12** to help prevent six types of cancer later in life.

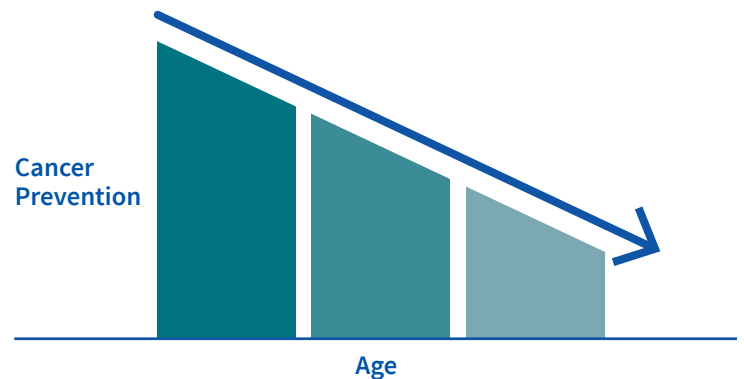


## Age Matters

When you vaccinate your child on time, you help protect them from HPV cancers. HPV vaccination works best when given before age 13.

**Vaccination at the recommended ages will prevent more cancers than vaccination at older ages.**

## Cancer Prevention Decreases as Age at Vaccination Increases



**On Time**  
Ages 9-12  
**2 Doses**  
6-12 months apart

**Late**  
Ages 13-14  
**2 Doses**  
6-12 months apart

**Late - Extra Dose**  
Ages 15-26  
**3 Doses**  
1st dose at visit one  
2nd dose 1-2 months later  
3rd dose 6 months after 1st dose

Hepatitis A is a viral infection transmitted by contaminated food and water. International travelers are at increased risk, but outbreaks have also been traced to restaurants, daycare centers and schools. The Centers for Disease Control and Prevention (CDC) recommends that all children receive two doses of a vaccine to prevent hepatitis A.

*Q. What is hepatitis A?*

A. Many people with hepatitis A virus infection develop a loss of appetite, vomiting, nausea, fatigue and jaundice, a yellowing of the eyes and skin. Symptoms can last for up to six months. However, some people who catch hepatitis A virus don't have any symptoms; this is particularly true of young children who then spread the infection unknowingly.

Hepatitis A virus infections — unlike hepatitis B virus infections — don't cause long-term liver disease (cirrhosis) or liver cancer. But hepatitis A can still cause hospitalization, a rapid overwhelming infection of the liver and death.

*Q. What is my child's risk of getting hepatitis A infection?*

A. Every year, thousands of people in the United States are infected with hepatitis A and approximately 50 to 100 die from the disease.

*Q. How is hepatitis A spread?*

A. Hepatitis A virus is found in the stools of people who are infected and is transmitted in contaminated food and water. It spreads easily in countries and cities with low standards for the handling and disposal of sewage; however, it can also spread in households, daycare centers, schools and restaurants when appropriate hand washing is not exercised, particularly after changing diapers and using restrooms and before handling food. Importantly, the virus can be transmitted by an infected person a week or two before symptoms begin.

*Q. What is the hepatitis A vaccine?*

A. The hepatitis A vaccine is made by taking hepatitis A virus and completely killing it with the chemical formaldehyde. Children inoculated with hepatitis A vaccine become immune and won't get hepatitis A in the future. Because the virus in the vaccine is not live, they can not get hepatitis A from the vaccine.

*Q. Is the hepatitis A vaccine safe?*

A. Yes. About five to 10 of every 100 children given the hepatitis A vaccine will have pain, warmth or swelling where the shot was given and about five of every 100 will have a headache.



# Hepatitis A: What you should know

## *Q. Who should get the hepatitis A vaccine?*

**A. The hepatitis A vaccine is recommended for all children between 12 and 23 months of age.** The vaccine is given as a series of two shots; the second shot is given six to 18 months after the first. Children not vaccinated between 12 and 23 months of age can be vaccinated at subsequent visits to the doctor during the years before school.

Adults who are at high risk of hepatitis A infection should also be immunized; these include people who will spend significant time with an adopted child during the first 60 days after arrival in the United States, such as close family members and babysitters; travelers to countries with high levels of hepatitis A; people with chronic liver disease or who get clotting factors; lab personnel working with the virus; injection drug users; and men who have sex with men.

Because people often never determine when or where they were infected with hepatitis A virus, anyone who wants to be protected should consider getting immunized.



## *Q. Do travelers need to get the hepatitis A vaccine?*

**A. Travelers can decrease their chances of getting hepatitis A by avoiding uncooked foods such as fish, vegetables, fruits and salads, food from street vendors, and ice and unbottled water; however, this plan is not foolproof.** Therefore, any traveler concerned about hepatitis A infection should consult a healthcare provider about getting the vaccine four weeks prior to traveling.

## *Q. Do the benefits of the hepatitis A vaccine outweigh the risks for my child?*

**A. Yes.** Every year, thousands of people in the United States are infected, and some are killed by hepatitis A virus. The hepatitis A vaccine does not cause any severe reactions. Therefore, the benefits of the hepatitis A vaccine clearly outweigh its risks.

Every year, thousands of people in the United States are infected with hepatitis A and approximately 50 to 100 die from the disease.

This information is provided by the Vaccine Education Center at The Children's Hospital of Philadelphia. The Center is an educational resource for parents and healthcare professionals and is composed of scientists, physicians, mothers and fathers who are devoted to the study and prevention of infectious diseases. The Vaccine Education Center is funded by endowed chairs from The Children's Hospital of Philadelphia. The Center does not receive support from pharmaceutical companies.

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