Dear Parent/Guardian:

The overall health and well-being of your child is very important. We at the Bradshaw Institute encourage your child to get annual well visits with their primary care provider and to receive all of the adolescent vaccinations currently recommended by the Centers for Disease Control and Prevention (CDC) for their age group. The CDC recommends the following vaccines for adolescents: HPV , Meningococcal ACWY and/or Meningococcal B vaccines (www.cdc.gov/vaccines). During the Bridges to a Brighter Future program this summer, we will be offering well child visits along with these immunizations to students who do not have a a primary care provider.

Through a partnership with South Carolina Department of Health and Environmental Control (SC DHEC) and the federally funded Vaccines for Children program (VFC) we will offer these vaccines during well child visits:

Meningococcal Vaccination -Pronounced (muh-nin-jeh-KOK-ul)

Vaccines can help prevent meningococcal disease, which is any type of illness caused by Neisseria meningitidis bacteria. There are 2 types of meningococcal vaccines available in the United States:

- Meningococcal conjugate or MenACWY vaccines (Menactra® and Menveo®)
- Serogroup B meningococcal or MenB vaccines (Bexsero® and Trumenba®)

All 11 to 12 year olds should get a meningococcal conjugate vaccine, with a booster dose at 16 years old. Teens and young adults (16 through 23 year olds) also may get a serogroup B meningococcal vaccine. CDC also recommends meningococcal vaccination for other children and adults who are at increased risk for meningococcal disease.

HPV Vaccination:

Two doses of HPV vaccine are recommended for children at ages 11–12; the vaccine can be given starting at age 9 years. Children who start the HPV vaccine series on or after their 15th birthday need three doses given over 6 months.

If you have any questions, please contact Melinda Lavallee-Turner, Program Coordinator for Community Pediatrics at the Bradshaw Institute, at 864-454-2341.

Thank you,

Bradshaw Institute School-based Health Center Team

Prisma Health School-based Health Forms

We are excited to offer your child well child visits through the Prisma Health School-based Health Clinic. In order for your child to be seen by the Prisma Health medical provider, you will need to complete the following forms located in this packet.

- Permission to Treat-Gives the Prisma Health medical provider permission to provide medical care to your child.
- Patient information/demographic sheet-Provides Prisma Health medical provider with necessary patient demographic and billing information.
- Vaccine Selection and permission forms- Allows you to select which vaccines you would like your child to receive.
- Sports Physical Form (if necessary)- For your child to play a school sport next school year (2021-2022)

Prisma Health School-based Health Providers

Kerry K. Sease, MD is a graduate of the University of South Carolina School of Medicine. She completed her Pediatric training with Greenville Health System and went on to continue her training at the Children's Hospital of Pittsburgh where she completed a General Academic Pediatric fellowship. During her fellowship, she also earned her MPH from the University of Pittsburgh School of Public Health. Dr. Sease currently serves as the Medical Director for Prisma Health Bradshaw Institute for Community Child Health & Advocacy. In this role, she oversees the work of Community Pediatrics, which includes Medical Legal Partnership, Population Health Management, School-based Health Centers, Obesity treatment and Children's Camps.

Holly Bryan (MSN, PNP-BC) received her undergraduate nursing degree from the University of North Carolina at Chapel Hill and completed her masters in nursing/pediatric nurse practitioner (PNP) education at the University of Alabama at Birmingham for which she was awarded the Outstanding Pediatric Nursing Graduate Student in MSN/Nursing. She has worked as a PNP in Pediatric Hematology-Oncology, Gastroenterology, and general pediatrics. Holly currently serves as the lead PNP in the Prisma Health School-based Health Centers. In this role, she travels among select Greenville County Schools to provide students with care for both acute and chronic conditions. In 2017, Holly was named Children's Hospital of Greenville Health System Caregiver of the Year, Physician Practices and Specialty Care.

Rebecca M. Saul, (PNP-BC) received her training at Vanderbilt University School of Medicine. She is a provider with Prisma Health Pediatric Associates-Spartanburg and is also a provider for Prisma Health New Impact, a healthy lifestyle program that benefits your entire family by using a multidisciplinary team approach that empowers children to develop active, healthy lifestyles by focusing on the eating and exercise behavior of the entire family.

GENERAL PERMISSION TO TREAT:

Emergency Department patients: Patients presenting to the Emergency Department have the right to receive an appropriate medical screening exam performed by a doctor, or other qualified professional, to determine whether they are suffering from an emergency medical condition or are in active labor, and if so, to receive stabilizing treatment (including delivery of a baby including the placenta) within the capabilities of the Prisma Health staff and facilities. Patients have these rights even if they cannot pay for services, do not have health insurance, or are not entitled to Medicare or Medicaid.

I am the patient named above (or the person authorized by law to make decisions for the patient). I give permission for Prisma Health and its physicians, healthcare providers, staff, and outside companies to perform routine hospital and healthcare services as applicable: including blood draws, medications, tissue disposal/donation, examinations, treatments, lab tests, anesthetics, therapy, transportation, evaluation and treatment services, and procedures, as may be necessary in accordance with the judgment of the provider(s), including appropriately supervised students, residents, and telehealth providers. **Treatment may be provided by authorized employees of Prisma Health and the University of South Carolina.** I acknowledge that no guarantee can be made concerning the results of treatments.

Diagnostic and laboratory procedures that may be ordered for me (and/or my newborn infant) include (but are not limited to) testing for diseases such as human immunodeficiency virus (HIV), hepatitis, any other diseases categorized as contagious or sexually transmitted diseases, and methicillin-resistant staphylococcus aureus (MRSA). I understand that I can discuss these tests with my health care provider and can tell my healthcare providers (nurses, technicians and physicians) if I do not want to be tested for any one or all of these diseases. If I refuse the tests, I will not be tested. However, if I do not refuse these tests, I may be tested and those results will be included in my medical record. If the test results are positive, the results will be shared with me. If a health care worker comes in direct contact with my blood or body fluids, I understand that South Carolina law allows my blood to be tested without my consent for the hepatitis B virus, hepatitis C virus, or HIV to determine whether or not the viruses are present. The results of the test(s) will be made available to me and to the healthcare worker who was exposed.

Unless otherwise discussed with me, I authorize Prisma Health to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment.

HEALTHCARE PROVIDERS: I understand that doctors who are providing services at Prisma Health are members of the Prisma Health medical staff, but they may not be employees or agents of Prisma Health. Many providers, including doctors, physician assistants, nurse practitioners and certified nurse midwives, are non-employed, independent providers. I understand that Prisma Health is not responsible for any act or omission by a provider who is not an employee or agent of Prisma Health. I also understand that Prisma Health is a medical teaching institution and that students and residents may be involved in my care with appropriate required supervision.

PERMISSION TO TREAT

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD-PARTY CLAIMS:
If I have insurance, I agree to assign to Prisma Health any and all rights including money from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, workers' compensation benefits, physician benefits (excluding any benefits payable to physicians who are not employees or agents of Prisma Health), injury benefits, or any other health, accident or welfare benefits of any type or form, whether insured or self-funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from the insurance policy. I also assign to doctors who are not employed by Prisma Health any proceeds of the foregoing benefits being paid by or on behalf of a third party or due from any insurance policy for services provided at Prisma Health (such as pathologists and other private doctors). I warrant and represent that any insurance or any plan which I assign is valid insurance and in effect and that I have the right to make this assignment. All amounts collected will be applied to my account. In the event a claim for payment submitted by Prisma Health to my insurance carrier or plan administrator is denied, I authorize Prisma Health to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of patients; plan or policy, appeal or file a legal/equitable action. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management. In the event I am a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C §1001 et seq., I designate Prisma Health as my authorized representative and grant to Prisma Health the authority to act on my behalf in pursuing and appealing a benefit determination under the plan. Such authority shall include the right to request and receive a copy of the plan description and/or summary of the plan description.

MEDICARE PATIENTS: If I am eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to Prisma Health on my behalf. I certify that the information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

FINANCIAL AGREEMENT: I understand that I am obligated to pay my account according to the regular rates and terms of Prisma Health, except for those services, provided in accordance with a clinical research trial, which are specifically identified in writing as services for which I am not obligated to pay. I do hereby appoint Prisma Health as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. To the extent not prohibited by law or contract, I hereby authorize Prisma Health to apply any overpayment it receives to any other account for which I am responsible at Prisma Health or its affiliated entities. If there is no other outstanding account(s) for which I am responsible, the payment will be posted to the intended account and a refund of any overpayment will be processed accordingly.

I understand that Prisma Health may obtain my credit report for review in collection of this debt. In the event that this account is placed with a collection agency or an attorney for collection, I will be responsible for paying all costs of collection, including attorney's fees.

DISCLOSURE/USE OF HEALTH INFORMATION: Uses and disclosures of my personal and health information are described in the Prisma Health Notice of Privacy Practices (NPP). I acknowledge by signing below that I have had the opportunity to receive a copy of the NPP. I also consent to the following:

- **Directory/Patient door**. Unless I inform hospital personnel otherwise, I consent to my name being listed in the hospital directory, along with my location, general condition, and religious preference to allow clergy visits.

PATIENT RIGHTS: I understand that I have certain rights and responsibilities that are set forth in the Patient Rights and Responsibilities handout. I acknowledge by signing below that I have received a copy of the Prisma Health Patient Rights and Responsibilities Handout.

PERSONAL VALUABLES/BELONGINGS: I agree not to bring dangerous items onto Prisma Health property. Prisma Health reserves the right to search my property and room for dangerous items. I understand that Prisma Health is not responsible for personal property kept in my room including false teeth, glasses, and other prosthetic devices. Prisma Health is NOT responsible for personal property, including money, unless Prisma Health has issued a receipt for safekeeping of the personal property. Prisma Health is a NO SMOKING facility. To ensure safety, I will allow Prisma Health to keep my smoking materials until discharge or may send them home with family or friends. I understand that this policy is strictly enforced.

CONTACTING PATIENTS: I understand that I may be contacted by my provider or Prisma Health and/or Prisma Health entities and its employees and outside contractors including debt collection companies through any contact information that I have provided to my provider, Prisma Health and/or Prisma Health entities for any purposes related to my medical diagnosis, treatment, fundraising, community service, unsolicited advertisements, marketing, payment for services, debt collections for bills owed, or for any other purpose related to treatment, payment or business operations. (This also applies to outside independent companies and doctors and their employees who provide services in or for Prisma Health facilities.) I may be contacted in ways that may cause me to be charged a fee, and I will be responsible to pay the fees related to cellphone, home phone, work phone, text message, email or fax usage for contacts.

I understand that I may be contacted by Prisma Health using automated dialing and/or artificial or prerecorded voice messages when contacting me by cell, home or work phone, patient room phone, paging service, specialized mobile radio service, radio common carrier service, or by or through any other service. I understand that this will allow Prisma Health to call me using phone numbers that I may have listed on National or State Do-Not-Call Registry(s).

Contacting by email or text messaging. To help coordinate your care, your provider will send you text messages and emails that include reminders for scheduling and scheduled appointments, recommended tests, and other information to help you manage your health. The messages may come from your provider, Prisma Health or from our partners who are helping to manage your care. The responsibility of scheduling and canceling appointments will still rest with you, but we hope this service will make things easier.

You may be contacted by Prisma Health using email for transmission of notices regarding billing statements. Such email notices and text messages are unencrypted and are, therefore, considered unsecure communications and will not include information specific to your clinical information, but they may include information that would be of interest to you because of your health condition. When we send text messages, we will never transmit your full name or address in the text message.

If you DO NOT wish to allow contacting in these manners, please notify a Prisma Health team member in the business office/patient access/ registration, respond to the “opt-out” directions in the text message or choose your communication preference in the patient portal.

I understand if I provide my cellphone number, home phone number, work phone number, and email address and do not tell anyone that I do not want to be contacted in the manners described, I am consenting to receive phone calls, text messages and emails for appointment scheduling and other healthcare reminders and information as described above. I will keep my provider informed of my up-to-date mobile number and email address at all times and notify my provider if the mobile number is no longer in my possession.

I understand that even if I do state that I do not wish to be contacted as described above, my provider, Prisma Health or our partners may still contact me by phone call for scheduling and scheduled appointments, recommended tests, and other information to help me manage my health.

PERMISSION TO TREAT

<u>HEALTHCARE ASSOCIATED INFECTIONS:</u> Healthcare-associated infections can be a complication of hospitalization. The SC Hospital Infections Disclosure Act, S.C. § 44-7-2410, requires hospitals to monitor and report targeted healthcare-associated infections to the SC Department of Health and Environmental Control (DHEC). These reports are available on the following website for public view: http://www.scdhec.gov/Health/FHPF/InfectionControlHIDA/HospitalInfectionControl/

I understand that the practice of medicine and the security of personal or health information is not an exact science and that not all risks can be eliminated and that NO GUARANTEES HAVE BEEN MADE TO ME.

I SIGN BELOW ACKNOWLEDGING THAT I HAVE READ, ASKED QUESTIONS AND UNDERSTAND AND AGREE TO ALL FOUR PAGES OF THIS FORM.

DATE/TIME	SIGNATURE OF WITNESS	SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE
DATE/TIME	SIGNATURE OF SECOND WITNESS (NECESSARY ONLY FOR TELEPHONE CONSENT)	PRINT NAME AND RELATIONSHIP IF OTHER THAN PATIENT

PRISMA HEALTH®

Patient Information

(please print)

Full legal name: ______________________ (Last / First / Middle) Preferred name: ______________________

Date of birth: ______________________ (Month/Day/Complete year) SS#: ______________________

Sex at birth: ☐ Male ☐ Female ☐ Intersex

Gender identity: ☐ Man ☐ Woman ☐ Transwoman ☐ Transman ☐ Nonbinary ☐ Another unlisted

What are your pronouns? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another ______________

Primary care physician: ______________________

Preferred pharmacy name: ______________________ Phone number: ______________________

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life partner ☐ Legally separated

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refused/Decline

Race: ☐ Caucasian (white) ☐ American Indian ☐ African American (Black) ☐ Hispanic ☐ Biracial ☐ Asian ☐ Other ☐ Unknown

Home address: ______________________ City: ______________ State: ________ ZIP: ____________

Mail to address: ______________________ City: ______________ State: ________ ZIP: ____________

County: ______________ Home phone: ( ) ______________ Cellphone: ( ) ______________

Preferred language: ______________________ Email: ______________________

Veteran: ____Yes ____No ____Unknown Religion: ______________________

Guarantor information *(If guarantor is self, skip to emergency contact)*

Parent/guardian presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: ______________________ (Last / First / Middle) Patient relation to guarantor: ______________________

Home phone: ( ) ______________________

Date of birth: ______________ SS#: ______________________ Cellphone: ( ) ______________________

Home address: ______________________ City: ______________ State: ______ ZIP: __________ Country: ______________

Mail to address *(if different)*: ______________________ City: ______________ State: ______ ZIP: __________ Country: ______________

Emergency contact *(Pediatric patients, please list someone other than parent(s)/guardian)*

Primary contact name: ______________________ Home phone: ( ) ______________________

Patient relation to emergency contact: ______________________ Cellphone: ( ) ______________________

Secondary contact name: ______________________ Home phone: ( ) ______________________

Patient relation to emergency contact: ______________________ Cellphone: ( ) ______________________

Employment

Patient employer: ______________________ Work phone: ______________ Ext: ________

Address: ______________________ City: ______________ State: ________ ZIP: ____________

Employment status: ☐ Full time ☐ Part time ☐ Self-employed ☐ Active military ☐ Student full time ☐ Student part time ☐ Retired date _______ ☐ Disabled ☐ Not employed ☐ Unknown

(Pediatric patients only) Parent/Guardian & immediate family information

Mother *(If the address, phone numbers and employer information are the same as guarantor, please indicate same.)*

Full name: ______________________ (Last / First / Middle) Nickname: ______________________

Date of birth: ______________________ (Month/Day/Complete year)

SS#: ______________________

Home address: ______________________ City: ______________ State: ________ ZIP: ____________

(if different from patient)

Home phone: ______________________ Cellphone: ( ) ______________________

Employer: ______________________ Work phone: ( ) ______________________ Ext: ________

Father *(If the address, phone numbers and employer information are the same as guarantor, please indicate same.)*

Full name: ______________________ (Last / First / Middle) Nickname: ______________________

Date of birth: ______________________ (Month/Day/Complete year)

SS#: ______________________

Home address: ______________________ City: ______________ State: ________ ZIP: ____________

(if different from patient)

Home phone: ______________________ Cellphone: ( ) ______________________

Employer: ______________________ Work phone:) ______________________ Ext: ________

Patient name_______________________ DOB _______________________

(Pediatric patients only) Brothers, sisters & other family members

Full name	*M or F*	*Date of birth*	*Relationship*	*Lives with child*
				Yes No
				Yes No
				Yes No
				Yes No

☐ **Check here if no insurance. And skip to authorization (below).**

Accident information

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.) ☐ Yes ☐ No

Type of accident:_______________Date of accident:_______________County of accident:_______________

Primary insurance information

SUBSCRIBER: This is the person who carries the insurance. If subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card:_______________________Date of birth: _______________
Month/Day/Complete year

Patient relationship to subscriber:_______________ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: _______________________ SS#: _______________

City, state, ZIP: _______________________ Home phone: _______________

Employer: _______________________ Work phone:_______________Ext. ________

Insurance co. name: _______________________ **Phone:**_______________

Policy/Cert #:_______________**Group no.:** _______________ **Effective date:** _______________

Subscriber Status: ☐ **Full time** ☐ **Part time** ☐ **Self-employed** ☐ **Active military** ☐ **Student full time**
☐ **Student part time** ☐ **Retired date** _______________ ☐ **Disabled** ☐ **Not employed**

Secondary insurance information

SUBSCRIBER: This is the person who carries the insurance. If subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card:_______________________Date of birth: _______________
Month/Day/Complete Year

Patient relationship to subscriber:_______________ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: _______________________ SS#: _______________

City, state, ZIP: _______________________ Home phone: _______________

Employer: _______________________ Work phone:_______________Ext. ________

Insurance co. name: _______________________ **Phone:**_______________

Policy/Cert #:_______________**Group no.:** _______________ **Effective date:** _______________

Subscriber status: ☐ **Full time** ☐ **Part time** ☐ **Self-employed** ☐ **Active military** ☐ **Student full time**
☐ **Student part time** ☐ **Retired date** _______________ ☐ **Disabled** ☐ **Not employed**

Authorization

I authorize medical evaluation and treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to Prisma Health for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of patient/guardian/guarantor:_______________________ **Date:**_______________

20-3017 9/20

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**

Office use only

10/30/2019 | 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.*

6 The National Vaccine Injury Compensation Program

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

7 How can I learn more?

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

VACCINE INFORMATION STATEMENT

Meningococcal B Vaccine: *What You Need to Know*

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

1 Why get vaccinated?

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

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

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

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

2 Meningococcal B vaccine

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

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

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

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

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

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

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

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

Your health care provider can give you more information.

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

4 Risks of a vaccine reaction

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

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

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

5 What if there is a serious problem?

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

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

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

6 The National Vaccine Injury Compensation Program

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

7 How can I learn more?

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

Office use only

School-based Health Center
Vaccine Selection Document

Student Name:____ DOB:_______________

School:____

Parent/Guardian Name (please print) :____

Please indicate which vaccine(s) you wish for your child to receive at their middle school vaccine clinic:

- ☐ HPV (Human Papillomavirus)
- ☐ Meningococcal ACWY (Menactra® and Menveo®)
- ☐ Meningococca B (Bexsero® and Trumenba®)

Parent/Guardian Signature:____Date:________________

A vaccine consent form **must** be completed for **EACH** vaccine that your student will receive, these forms are the next pages in the packet.

Bradshaw Institute for Community Child Health & Advocacy
School-Based Health Center

Meningococcal ACWY VACCINE CONSENT FORM

Student Name: ____

Date of Birth: ____

Meningococcal ACWY Vaccine Immunization

I have received and read the Tdap Vaccine Information Sheet (included in this packet) published on 2/24/2015 and have no further questions regarding the immunization. My childhas nocontraindications to the vaccine.

Parent/Legal Representative Initial: ____________

Date: _______________

I consent to immunization with Meningococcal ACWY : ______________________________________
(Parent/ Legal Representative Signature)

*Date:*_________________________

Allergies to foods or medicines? (Circle one) *None* *Yes- please list*__________________________

FOR MEDICAL USE ONLY

Temperature: __________________

*Lot #:*______________________ *Exp Date:*___________________ *Manufacturer:*________________________

Site/amount: 0.5ml. IM *R* *L* *deltoid*

Nurse/CMA Signature: ____

Date: ________________________________ *Time:* ______________________________

Bradshaw Institute for Community Child Health & Advocacy
School-Based Health Center

Meningococcal B VACCINE CONSENT FORM

Student Name: ____

Date of Birth: ____

Meningococcal B Vaccine Immunization

I have received and read the Tdap Vaccine Information Sheet (included in this packet) and have no further questions regarding the immunization. My childhas nocontraindications to the vaccine.

Parent/Legal Representative Initial: ____________

Date: _______________

I consent to immunization with Meningococcal B: ____
(Parent/ Legal Representative Signature)

*Date:*_________________________

Allergies to foods or medicines? *(Circle one)* *None* *Yes- please list*__________________________

FOR MEDICAL USE ONLY

Temperature: __________________

*Lot #:*______________________ *Exp Date:*___________________ *Manufacturer:*________________________

Site/amount: 0.5ml. IM *R* *L* *deltoid*

Nurse/CMA Signature: ____

Date: ________________________________ *Time:* ______________________________

Bradshaw Institute for Community Child Health & Advocacy
School-Based Health Center

HPV (Human Papillomavirus) VACCINE CONSENT FORM

Student Name: ______________________________

Date of Birth: ______________________________

HPV (Human Papillomavirus) Immunization

I have received and read the Tdap Vaccine Information Sheet (included in this packet) published on 2/24/2015 and have no further questions regarding the immunization. My childhas nocontraindications to the vaccine.

Parent/Legal Representative Initial: __________

Date: __________

I consent to immunization with HPV: ______________________________
(Parent/ Legal Representative Signature)

Date: __________

Allergies to foods or medicines? *(Circle one)* *None* *Yes- please list* __________

FOR MEDICAL USE ONLY

Temperature: __________

Lot #: __________ *Exp Date:* __________ *Manufacturer:* __________

Site/amount: 0.5ml. IM *R* *L* *deltoid*

Nurse/CMA Signature: ______________________________

Date: __________ *Time:* __________

Preparticipation Physical Evaluation - History Form

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name:____Date of Birth:_____________________________Sex: ______

Date of Examination:_________________________Sport(s): ____

List past and current medical conditions: ____

Have you ever had surgery? If yes, list all past surgical procedures: ____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional): ______________

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects): ___________________

General Questions. Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
Heart Heath Questions About You	**Yes**	**No**
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography.		
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
Health Questions About Your Family	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (*including drowning or unexplained car accident*)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QTsyndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?		
Bone and Joint Questions	**Yes**	**No**
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a game or practice?		
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		

Medical Questions	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, tingling, or weakness in your arms or leg, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special Diet or do you avoid certain types of foods?		
28. Have you ever had an eating disorder?		
Females Only	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain a "Yes" answer here: ____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: ____

Signature of parent or guardian: ____

Date ________________________

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