School-Based Immunization Consent
Sangamon County Department of Public Health

Name _____

Birthday _____

Date _____

CONSENT and ACKNOWLEDGEMENT Receipt of Joint Notice of Privacy Practices

I do hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices from the Sangamon County Department of Public Health (SCDPH) with and effective date of 9/23/13.

I understand that SCDPH is already authorized to the use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

Authorization to Receive Treatment

I do hereby authorize the Sangamon County Department of Public Health (SCDPH) staff to provide care on my or my dependent's behalf and to have access to information necessary for the delivery of health care services. I understand SCDPH works collaboratively with teaching institutes in the community and I or my dependent may see a medical resident, medical student, and/or a nursing student. I agree that this authorization covers all medical services related to the vaccination of my child. I recognize that I may not be present when my child receives vaccinations.

Informed Consent

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Departments of Human Services and Public Health. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit and evaluation purpose. Necessary information, without any client's name, will be sent to federal agencies that fund these services.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

A. I authorize SCDPH to collect information during the enrollment/registration process.

B. This authorization covers all the medical, social and financial information about the participant, including; participant background and demographic information; health visit information; medical and developmental history; prenatal, birth and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care.

C. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done

before I revoked it. I also understand and agree not to hold the Illinois Department of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.

D. A photo static copy/facsimile of this consent will be as valid as the original.

Signature _____

Signed by Witness _____

CLIENT INFORMATION SHEET

PLEASE PRINT

TODAY'S DATE ____/____/____

CLIENT'S NAME _____
First M.I. Last

ADDRESS _____

_____
City State Zip Township

TELEPHONE (DAYTIME) _____ (EVENING) _____

BIRTHDATE ____/____/____ SEX: ☐ MALE ☐ FEMALE

RACE: ☐ WHITE ☐ BLACK ☐ OTHER _____

HISPANIC ORIGIN: ☐ YES ☐ NO

LAST 4 DIGITS OF SOCIAL SECURITY NUMBER ____ ____ ____ ____

PARENT/GUARDIAN _____

DOCTOR _____ SCHOOL/DAYCARE _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Pursuant to the Health Insurance Portability and Accountability Act of 1996, I hereby authorize the Sangamon County Department of Public Health to release/disclose the nature or details of service provided on behalf of the client to the following:

☐ Doctor ☐ Illinois Department of Public Health ☐ Other:_____
☐ School/Daycare ☐ Department of Children and Family Services

This authorization is in effect for the following time period: from _____ to _____
(Start Date) (End Date)

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that if the health department has already used or released my health information in reliance on this authorization, that I cannot revoke the authorization. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by law.

I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that this authorization is valid until the "End Date" listed above, or until I revoke it in writing by delivering a written revocation to the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

X_____
Signature of Parent/Guardian/Client

Rev. 4/10

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

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. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, 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 federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	Has health insurance that covers vaccines	**Other underinsured	***Enrolled in CHIP

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.

*** 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. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

****Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers. CHIP (All Kids) recipients are eligible for vaccines purchased by the State and distributed by the Illinois Vaccines for Children (VFC) program to providers enrolled in the VFC program.*

Immunization Clinic Checklist

Client Name__________________________ Date of Birth____/____/____ Age_____

Race: ____White ____Black or African American ____Asian ____American Indian/Alaska Native ____Pacific Islander

Ethnicity: ____Hispanic ____Non Hispanic

(Circle Yes/No)

Y N 1. Has client been sick with something more than a cold or been on any medication in the past week?

Y N 2. Is the client running a fever?

Y N 3. Has the client received a TB skin test in the last 30 days, or an Immunization in the past 30 days? If immunization , which one(s)____________________.

Y N 4. Does the client or any immediate family member have any disease that lowers the body's resistance to infection such as heart disease, asthma, kidney disease, metabolic disease (e.g. diabetes), blood disorder, cancer, leukemia, or AIDS?

Y N 5. Has the client had a severe reaction following an immunization?

Y N 6. Has the client **ever** had a seizure, brain or nervous system disorder or had Guillain-Barre syndrome?

Y N 7. In the past year, has client received any unusual injections (gamma globulin, prednisone, other steroids, anticancer, radiation, blood transfusion, blood products or an antiviral drug).

Y N 8. Is the client allergic to: **Neomycin** (antibiotic), **Mercury, Gelatin, Latex or Eggs?** Can the client eat lightly cooked eggs (e.g. scrambled eggs)?________________________. Is there any other reaction to eggs?_______________________________.

Y N 9. **For Women:** Is the client pregnant or planning pregnancy within the next 3 months.

Y N 10. Does the client or any immediate family member have a history of? genetic problems, i.e., heart or birth defects, any syndrome, blood or chromosomal abnormalities?

Y N 11. If you answered "yes" to question #10, would you like information or wish to speak with a genetic nurse?

□□

Administration of Vaccination(s) Consent

I have read and understand the possible side effects described in the Vaccine Information Handout or the Important Information Statement that could be caused by the vaccine(s).

I understand the benefits and risks and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Adolescents ages 10 through 20 years old will be asked to remain in the clinic for 15 minutes after immunization for safety reasons.

________________________________ ________________________________

Signature of Client or Parent/Guardian Date Signature of Nurse Interviewer Date

For Office Use Only – Patient Name_____

Immunization V.I.S. Date/Lot#	Immunization V.I.S. Date/Lot#	Immunization V.I.S. Date/Lot#
DTap_____	MMR_____	Td_____
Hep B_____	Varicella_____	Tdap_____
Hib_____	Hep A_____	Pneumococcal_____
IPV_____	HPV_____	Shingles_____
Prevnar_____	Meningitis_____	Rabies_____
Rotavirus_____	Yellow Fever_____	Typhoid_____
Multi-Vaccine_____		

Nurses Note

Client Age:_____ **Client here for**_____

☐ **DTaP#**____**(Pentacel/Pediarix/Daptacel/Kinrix)** **Hib #**_____ **IPV #**_____ **Hep B #**_____ **Rotateq #**_____

Prevnar 13#____ **Hep A #**____ **Varivax #**____ **MMR #**____ **TD #**____

Tdap (Boostrix/Adacel) **Menactra#**____ **Gardasil #**____ **Other**_____given.

Pt. Tolerated well.

Complications:_____.

Side effects reviewed with Parent/Guardian. VIS's given.

Fever control information sheet given and told parent/guardian to F/U with primary care physician PRN.

Other instructions:_____.

Other services provided:_____.

Referrals:_____.

RTV discussed to F/U in/on_____for the following:

DTaP#____**(Pentacel/Pediarix/Daptacel/Kinrix)** **Hib #**_____ **IPV #**_____ **Hep B #**_____ **Rotateq #**_____

Prevnar 13#____ **Hep A #**____ **Varivax #**____ **MMR #**____ **TD #**____

Tdap (Boostrix/Adacel) **Menactra#**____ **Gardasil #**____ **Other**_____

Other Comments_____

_____

_____

_____

_____

_____

RN/ANP Signature:_____ Date_____

PERSONAL HEALTH SERVICES RENDERED SLIP

04/29/15

Sangamon County Department of Public Health 2833 South Grand Avenue East, Springfield, IL 62703 217.535.3102
Tax ID #37-6002039 NPI #1164448262

Last Name: _____ First: _____ M.I._____

Date of Birth: _____/_____/_____ Age:_____ Male / Female (circle one) Client #_____

Race: ____ (10 – White; 20 - African American; 50 – Asian; 60 – American Indian/Alaska Native; 70 – Native Hawaiian/Oth Pac Islndr)

Ethnicity: _____ (00 – Not Hispanic/Latino; 01- Hispanic/Latino)

Home Address:_____

City:_____ State:__IL_____ Zip:_____

Daytime Phone Number_____

Insurance: We accept the following **PPO** and **HMO** Insurance Plans

_____Aetna 60054	_____BC/BS SB621	_____Coventry 25133	_____Cigna 62308	_____Health Alliance 77950
_____Humana 61101	_____Meridian 13189	_____Molina 20934	_____IPH SKIL0	

ID/Subscriber Number:_____ Group Number:_____

Medicaid Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Medicare Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ - ___

Date of Service:

Schedule of Discounts Eligibility Worksheet

Total of Services: _____ + _____ + _____ + _____ + _____ + _____ + _____ = $_____

Discount: ____90% ____75% ____50% ____25% ____0% ____VFC ____VFA

VFC and VFA vaccines: request $10 administrative fee be paid per vaccine

Discounted Price: _____ + _____ + _____ + _____ + _____ + _____ + _____ = $_____

Total **Amount Due** for Services Today:_____

Proof of Income Provided for Discount *(make copy for chart)*: ____Paystub ____W-2 ____1040 ____Other

Total **Amount Paid** for Services Today: $_____ Payment Received By: _____

*(Approval required by supervisor if Amount Due & Amount Paid not equal)*_____

Payment Source: Cash_____ Check_____ Credit/Debit Card_____ Insurance_____

For Credit/Debit Card Payments: 16 Digit #_____ ***CRV 3 Digit #***_____

Expiration Date:____/____ ***Zip Code for Address of Card***_____

IMMUNIZATIONS

	Rev Code		Price	CPT Code	Dx Code
	PADA	ADACEL-Tdap (10 y.o. thru 64 y.o.)	$65.00	90715	V061
	PBOO	BOOSTRIX-Tdap (10 y.o. - any age adult)	$63.00	90715	V061
	PDTP	DTaP (6 weeks - 6 y. o.)	$51.00	90700	V061
	PGAR	GARDASIL (9 y.o. - 26 y.o.)	$171.00	90649	V04.89
	PHA1	Hepatitis A (under 19 y.o.)	$53.00	90633	V053
	PHA2	Hepatitis A (19 y.o and over)	$77.00	90632	V053
	PHB1	Hepatitis B (under 19 y.o.)	$46.00	90744	V053
	PHB2	Hepatitis B (19 y.o. and over)	$77.00	90746	V053
	PHI2	HIB (PRP-T) (6 weeks - 4 y.o.)	$51.00	90648	V0381
	PIPV	IPV Polio (6 weeks - any age adult)	$52.00	90713	V040
	PKIN	KINRIX (4 y.o. - 6 y.o.)	$75.00	90696	V063
	PMNA	Menactra (9 months thru 54 y.o.)	$137.00	90734	V0389
	PMNO	Menomune (2 y.o - any age adult)	$147.00	90733	V0389
	PMMR	MMR II (12 months - any age adult)	$84.00	90707	V064
	PPED	Pediarix (6 weeks thru 6 y.o.)	$98.00	90723	V068
	PPEN	PENTACEL (6 weeks thru 4 y.o.)	$107.00	90698	V068
	PPNE	Pneumovax 23 (2 y.o. - any age adult)	$96.00	90732	V0382
	PPRV	Prevnar 13 (6 weeks - any age adult)	$176.00	90670	V0382
	PRAB	Rabies (any age)	$319.00	90675	V045
	ARTQ	RotaTeq (6 weeks thru 31 weeks)	$99.00	90680	V0489
	PTD	Td (7 y.o. - any age adult)	$48.00	90714	V065
	PTWN	Twinrix (18 y.o. - any age adult)	$118.00	90636	V053
	PTY1	Typhoid (2 y.o. - any age adult)	$78.00	90691	V031
	PVAR	Varivax (12 months - any age adult)	$124.00	90716	V054
	PYEL	Yellow Fever (9 mos - 59 y.o.)	$143.00	90717	V044
	PZOS	Zostavax (50 y.o. - any age adult)	$198.00	90736	V04.89

NEW/ESTABLISHED WELL VISITS

	Type	Dx Code
	Routine/Well Infant/Child Exam (0-17)	V202
	School/Sports/Camp Child Exam (0-17)	V703
	PreSchool/Pre-Employ Child Exam (0-17)	V705
	Daycare Child Exam (0-17)	V709
	Adult Physical (18-any age adult)	V700
	Adult Pre-Employ Exam (18 - any age adult)	V705

	Rev Code	NEW CLIENT	Price	CPT Code
	PNW0	0 thru 11 months	$50.00	99381
	PNW1	1 thru 4 y.o.	$50.00	99382
	PNW2	5 thru 11 y.o	$50.00	99383
	PNW3	12 thur 17 y.o.	$50.00	99384
	PNW4	18 y.o. thru 39 y.o.	$60.00	99385
	PNW5	40 y.o. thru 64 y.o.	$60.00	99386
	PNW6	65 y.o. - any age adult	$60.00	99387
	Rev Code	ESTABLISHED CLIENT	Price	CPT Code
	PES0	0 thru 11 months	$50.00	99391
	PES1	1 thru 4 y.o.	$50.00	99392
	PES2	5 thru 11 y.o	$50.00	99393
	PES3	12 thur 17 y.o.	$50.00	99394
	PES4	18 y.o. thru 39 y.o.	$60.00	99395
	PES5	40 y.o. thru 64 y.o.	$60.00	99396
	PES6	65 y.o. - any age adult	$60.00	99397

Client Name:_____ CLIENT #:_____

DOB:_____

IBCCP/IWP SERVICES

	APBE	Breast Exam Only (New Client)		99201	V76.10
	APPE	Pelvic Exam Only (New Client)		99202	V72.31
	APPB	Pelvic & Breast Exam (New Client)		99203	V72.31
	APB1	Breast Exam Only (Estab. Client)		99212	V76.10
	APP1	Pelvic Exam Only (Estab. Client)		99212	V72.31
	ABPE	Pelvic & Breast Exam (Estab. Client)		99213	V72.31
	ARRC	Risk Reduction Counseling		99401	V65.49
	AGLU	Blood Glucose		82947	V77.1
	AHBA	HbA1C (Diabetic Testing)		83036	V77.1
	ALIP	Lipid Profile		80061	V77.91

ADULT CLINIC VISITS

	Rev Code		Price	CPT Code	Dx Code
	ANCL	New Client - 10 Minute Visit	$20.00	99201	
	ANCL	New Client - 20 Minute Visit	$40.00	99202	
	ANCL	New Client - 30 Minute Visit	$58.00	99203	
	ANCL	New Client - 45 Minute Visit	$87.00	99204	
	AECL	Established Client - 5 Minute Visit	$15.00	99211	
	AECL	Established Client - 10 Minute Visit	$19.00	99212	
	AECL	Established Client - 15 Minute Visit	$29.00	99213	
	AECL	Established Client - 25 Minute Visit	$48.00	99214	

PROCEDURES AND ASSESSMENTS

	PTB1	TB Skin Test	$15.00	86580	V74.1
	ADAS	Adult Assessment (Contract Only)	$30.00		
	PFLO	Fluoride Treatment (Medicaid)	$30.00	D1206	V202
	PAS1	Ages & Stages Questionnaire	$30.00	96110	V202
	PPRE	Prenatal Edinburgh	$17.00	H1000	V220
	PPPE	Postpartum Edinburgh	$17.00	99420	V242
	PLFS	Capillary Blood Draw	$15.00	36416	V202
	PLVN	Venous Blood Draw	$28.00	36415	V202

STD SERVICES

	STD1	Risk Reduction Counseling	$42.00 Pkg Price	99401	V65.49
		Gonorrhea - Urine Probe		87591	V74.5
		Chlamydia - Urine Probe		87491	V73.98
		Gram Stain - Swab		87207	V7260
		HIV Antibody - I, II Anitbody; P24 Antigen		87806	V029
		Rapid Plasma Reagin (RPR)		86592	V74.5
		Wet Mount		87210	V7260
	STD2	Risk Reduction Counseling	$42.00 Pkg Price	99401	V65.49
		HIV Antibody - I, II Anitbody; P24 Antigen		87806	V029
		Rapid Plasma Reagin (RPR)		86592	V74.5

STD SERVICES Non-Package Pricing

	ARRC	Risk Reduction Counseling	$29.00	99401	V65.49
	ATRT	Treatment Service (Rx)	$25.00	99211	V016
	AURG	Gonorrhea - Urine Probe	$0.00	87591	V74.8
	AURC	Chlamydia - Urine Probe	$0.00	87491	V73.98
	AGRM	Gram Stain - Swab	$0.00	87207	V7260
	AHIV	HIV Antibody - I, II Anitbody; P24 Antigen	$39.00	87806	V029
	ARPR	Rapid Plasma Reagin (RPR)	$32.00	86592	V7260
	AHPC	Hepatitis C Antibody	$46.00	86803	V7260
	AHT1	Herpes Type I - Swab	$71.00	87529	V73.99
	AHT2	Herpes Type II - Swab		87529	V73.99
	AHPV	HPV Treatment - Circle Location below Penis (54050) Anus (46900) Vulva (56501) Vagina (57061)	$15.00	see circled location	0781
	ADKF	Dark Field	$15.00	87164	V7260
	AWET	Wet Mount - Circle Type below BV (616.10) Trich (13101) Yeast (112.1) Normal (V7231)	$15.00	87210	see circled type

LAB SERVICES

	AGLU	Blood Glucose	$15.00	82947	V77.1
	AHBA	HbA1C (Diabetic Testing)	$15.00	83036	V77.1
	PHEM	Hgb (Hemoglobin)	$15.00	85018	V202
	ALIP	Lipid Profile	$20.00	80061	V77.91
	ADIP	Urine Dip	$15.00	81000	V72.60
	PPTP	Urine Pregnancy Positive	$15.00	81025	V7242
	PPTN	Urine Pregnancy Negative	$15.00	81025	V7241
	APA5	5 Panel Drug Screen	$35.00	80101	V72.60
	AP11	11 Panel Drug Screen	$47.00	80101	V72.60
	ALCO	Alcohol Screen	$40.00	82055	V72.60
		Pap Smear	$0.00		

Service Performed by:_____

Date of Service:_____

CONSENT and ACKNOWLEDGMENT

Receipt of Joint Notice of Privacy Practices

I, _____ do hereby consent to allow the Sangamon
(print name of client)
County Health Department (HD) and its designated employees and contractors to perform a medical evaluation and treat conditions found therein. I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the HD is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the HD dated September 23, 2013.

Signed _____ Date _____

Signed _____ Date _____

Signed _____ Date _____

Signed _____ Date _____

Signed _____ Date _____

Check if any of the following apply:

☐ Parent or Guardian of minor ☐ Health Care Surrogate
☐ Power of Attorney for Health Care ☐ Mental Health Treatment Preference Declaration Agent
☐ Guardian with Power to make Health Care Decisions

FOR STAFF USE ONLY:
I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of the Sangamon County Department of Public Health. The acknowledgment was not obtained because:

☐ Client Refuses to Sign

☐ Other (specify): _____

Staff Member's Initials _____ Date _____

Staff Member's Initials _____ Date _____

Staff Member's Initials _____ Date _____

Staff Member's Initials _____ Date _____

*** Note to Staff ~ Place Acknowledgment in patient's medical record*

VACCINE INFORMATION STATEMENT

Meningococcal Vaccines

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 What is meningococcal disease?

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.

Meningococcal disease also causes blood infections.

About 1,000–1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10–15% of these people die. Of those who live, another 11%–19% lose their arms or legs, have problems with their nervous systems, become deaf, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16–21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

2 Meningococcal vaccine

There are two kinds of meningococcal vaccine in the U.S.:

- Meningococcal conjugate vaccine (**MCV4**) is the preferred vaccine for people 55 years of age and younger.
- Meningococcal polysaccharide vaccine (**MPSV4**) has been available since the 1970s. It is the only meningococcal vaccine licensed for people older than 55.

Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. There are other types of meningococcal disease; the vaccines do not protect against these.

3 Who should get meningococcal vaccine and when?

Routine vaccination

Two doses of MCV4 are recommended for adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16.

Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

Other people at increased risk

- College freshmen living in dormitories.
- Laboratory personnel who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has persistent complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

Children between 9 and 23 months of age, and anyone else with certain medical conditions need 2 doses for adequate protection. Ask your doctor about the number and timing of doses, and the need for booster doses.

MCV4 is the preferred vaccine for people in these groups who are 9 months through 55 years of age. MPSV4 can be used for adults older than 55.

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

4 Some people should not get meningococcal vaccine or should wait.

- Anyone who has ever had a severe (life-threatening) allergic reaction to a previous dose of MCV4 or MPSV4 vaccine should not get another dose of either vaccine.
- Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine. *Tell your doctor if you have any severe allergies.*
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover. Ask your doctor. People with a mild illness can usually get the vaccine.
- Meningococcal vaccines may be given to pregnant women. MCV4 is a fairly new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed. The manufacturers of MCV4 maintain pregnancy registries for women who are vaccinated while pregnant.

Except for children with sickle cell disease or without a working spleen, meningococcal vaccines may be given at the same time as other vaccines.

5 What are the risks from meningococcal vaccines?

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

Brief fainting spells and related symptoms (such as jerking or seizure-like movements) can follow a vaccination. They happen most often with adolescents, and they can result in falls and injuries.

Sitting or lying down for about 15 minutes after getting the shot—especially if you feel faint—can help prevent these injuries.

Mild problems

As many as half the people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

A small percentage of people who receive the vaccine develop a mild fever.

Severe problems

Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.

6 What if there is a serious reaction?

What should I look for?

Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

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

VAERS is only for reporting reactions. They do not give medical advice.

7 The National Vaccine Injury Compensation Program

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

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

8 How can I learn more?

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

Vaccine Information Statement (Interim)

Meningococcal Vaccine

10/14/2011

42 U.S.C. § 300aa-26

Office Use Only

JOINT NOTICE OF PRIVACY PRACTICES
Sangamon County Health Department

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Sangamon County Health Department (HD) works with other practitioners in delivering services to you. The practitioners include doctors and other professionals who are not part of the HD's workforce. All of these practitioners will follow this Joint Notice of Privacy Practices in delivering service to you. These practitioners include, but are not limited to: Physicians, Medical Residents, Medical Students, Billing Services, and other Business Associates of the HD. The HD and the practitioners involved in your care create a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. The uses and disclosures described in this Notice are applicable to the HD and all of the practitioners (collectively "we") who are part of this Joint Notice of Privacy Practices while they are delivering services at a HD facility or on behalf of the HD. This Joint Notice does not apply to service providers who are not part of the HD when they deliver services elsewhere or only on their own behalf.

We are required by federal and state law to maintain the privacy of your public health information (PHI). We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

This is a list of some of the types of uses and disclosures of PHI that may occur:

Treatment: We obtain medical information about you in treating you. This medical information is called "protected health information" or "PHI". Your PHI is used by us to treat you. For example, we refer to PHI in treating you at the HD. We may also send your PHI to another physician or counselor to which we refer you for treatment. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our clients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law.

Public Health: We may use and disclose your health care information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI by the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Immunizations: We may release information regarding immunizations to a school or other facility with your permission.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclose PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising: If we undertake any fundraising activities, we may contact you about the fundraising activity. You may opt-out of receiving fundraising information. Instructions to do so will be provided if you make a request to opt out.

Marketing: We do not typically engage in marketing activities, and would need your authorization to do so.

Sale of PHI: We will not sell your PHI without your authorization.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights: You have certain rights under federal privacy laws relating to your PHI. Some of these rights are described below.

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to agree to your request. We will agree to your restriction if you request that we not bill your health plan and you have paid for your services in full in advance.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, we will accommodate it.

Inspect and Access: You have a right to inspect information used to make decisions about your care. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options. You may copy your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies. Mailing costs may also apply if that is requested.

Amendments of your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of you PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Breach: If there is a breach affecting your unsecured PHI, we will notify you.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at the HD offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with the HD by calling our Privacy Officer at (217) 535-3100. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

We maintain a facility directory so that if family or friends ask us about your condition, we can tell them general information and the fact that you are here. If you do not want us to tell anyone you are here, please tell us now.

We are required to abide with terms of the Notice currently in effect, however, we may change this Notice. If we materially change this Notice, you can get a revised Notice from our website at www.scdph.org or by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

If we seek help from individuals or entities who are not part of this Notice in our treatment, payment, or health care operations activities, we will require those persons follow this Notice unless they are already required by law to follow the federal privacy rule.

EFFECTIVE DATE: September 23, 2013