

## 12, 13, 14 and 15 Year Well Check

### **Forms Included in this packet:**

- 1) HPV Vaccine Information Sheet
- 2) Immunization Questionnaire
- 3) Vaccines For Children Form
- 4) TB Risk Assessment

**Please fill these forms out and bring them to the appointment with you.**

### **At each appointment you will be asked for the following:**

Driver's License (or state issued ID card)

Current Insurance Card

Copay (If you cannot pay your copay, please call to reschedule your appointment)

Confirmation of your demographic information and to provide any missing information. (This can be done online via our patient portal)

### **To avoid FEES:**

- 1) Call to reschedule or cancel appointments no less than 24 hours before your scheduled appointment time.
- 2) Bring all forms you need with you and request them during the appointment.
- 3) Call to add an additional child(ren) to an existing appointment and understand that a change in time may be necessary to accommodate your need.

## VACCINE INFORMATION STATEMENT

# HPV Vaccine Gardasil® (Human Papillomavirus)

## 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 What is HPV?

Genital **human papillomavirus (HPV)** is the most common sexually transmitted virus in the United States. More than half of sexually active men and women are infected with HPV at some time in their lives.

About 20 million Americans are currently infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact.

Most HPV infections don't cause any symptoms, and go away on their own. But HPV can cause **cervical cancer** in women. Cervical cancer is the 2nd leading cause of cancer deaths among women around the world. In the United States, about 12,000 women get cervical cancer every year and about 4,000 are expected to die from it.

HPV is also associated with several less common cancers, such as vaginal and vulvar cancers in women, and anal and oropharyngeal (back of the throat, including base of tongue and tonsils) cancers in both men and women. HPV can also cause genital warts and warts in the throat.

There is no cure for HPV infection, but some of the problems it causes can be treated.

### 2 HPV vaccine: Why get vaccinated?

The HPV vaccine you are getting is one of two vaccines that can be given to prevent HPV. It may be given to both males and females.

This vaccine can prevent most cases of cervical cancer in females, if it is given before exposure to the virus. In addition, it can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

Protection from HPV vaccine is expected to be long-lasting. But vaccination is not a substitute for cervical cancer screening. Women should still get regular Pap tests.

### 3 Who should get this HPV vaccine and when?

*HPV vaccine is given as a 3-dose series*

1st Dose	Now
2nd Dose	1 to 2 months after Dose 1
3rd Dose	6 months after Dose 1

Additional (booster) doses are not recommended.

#### Routine vaccination

- This HPV vaccine is recommended for girls and boys **11 or 12 years of age**. It *may* be given starting at age 9.

#### Why is HPV vaccine recommended at 11 or 12 years of age?

HPV infection is easily acquired, even with only one sex partner. That is why it is important to get HPV vaccine before any sexual contact takes place. Also, response to the vaccine is better at this age than at older ages.

#### Catch-up vaccination

This vaccine is recommended for the following people who have not completed the 3-dose series:

- Females 13 through 26 years of age.
- Males 13 through 21 years of age.

This vaccine *may* be given to men 22 through 26 years of age who have not completed the 3-dose series.

It is *recommended* for men through age 26 who have sex with men or whose immune system is weakened because of HIV infection, other illness, or medications.

HPV 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

## 4 Some people should not get HPV vaccine or should wait.

- Anyone who has ever had a life-threatening allergic reaction to any component of HPV vaccine, or to a previous dose of HPV vaccine, should not get the vaccine. Tell your doctor if the person getting vaccinated has any severe allergies, including an allergy to yeast.
- HPV vaccine is not recommended for pregnant women. However, receiving HPV vaccine when pregnant is not a reason to consider terminating the pregnancy. Women who are breast feeding may get the vaccine.
- People who are mildly ill when a dose of HPV vaccine is planned can still be vaccinated. People with a moderate or severe illness should wait until they are better.

## 5 What are the risks from this vaccine?

This HPV vaccine has been used in the U.S. and around the world for about six years and has been very safe.

However, any medicine could possibly cause a serious problem, such as a severe allergic reaction. The risk of any vaccine causing a serious injury, or death, is extremely small.

Life-threatening allergic reactions from vaccines are very rare. If they do occur, it would be within a few minutes to a few hours after the vaccination.

Several **mild** to **moderate** problems are known to occur with this HPV vaccine. These do not last long and go away on their own.

- Reactions in the arm where the shot was given:
  - Pain (about 8 people in 10)
  - Redness or swelling (about 1 person in 4)
- Fever:
  - Mild (100° F) (about 1 person in 10)
  - Moderate (102° F) (about 1 person in 65)
- Other problems:
  - Headache (about 1 person in 3)
- Fainting: Brief fainting spells and related symptoms (such as jerking movements) can happen after any medical procedure, including vaccination. Sitting or lying down for about 15 minutes after a vaccination can help prevent fainting and injuries caused by falls. Tell your doctor if the patient feels dizzy or light-headed, or has vision changes or ringing in the ears.

Like all vaccines, HPV vaccines will continue to be monitored for unusual or severe problems.

## 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](http://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](http://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](http://www.cdc.gov/vaccines)

## Vaccine Information Statement (Interim) HPV Vaccine (Gardasil)

5/17/2013

42 U.S.C. § 300aa-26

Office Use Only



Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (mo.) (day) (yr.)

# Screening Questionnaire for Child and Teen Immunization



**For parents/guardians:** The following questions will help us determine which vaccines your child may be given today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, or any vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g., diabetes), or a blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child had a seizure, brain, or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Form reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Did you bring your child's immunization record card with you?**      yes     no

It is important to have a personal record of your child's vaccinations. If you don't have a personal record, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care for your child. Your child will need this important document for the rest of his or her life to enter day care or school, for employment, or for international travel.

# Illinois Department of Public Health

## Patient Eligibility Screening Record

Vaccines for Children Program (VFC)

VFC Eligibility screening must take place with each immunizations visit to ensure the child's eligibility status has not changed.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Full Name: \_\_\_\_\_

Child's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian name: \_\_\_\_\_

Is your practice/clinic a federally qualified health center (FQHC) or rural health clinic (RHC) Yes\_\_ No\_X

If you answered "Yes" you must have a photocopy or electronic copy of your FQHC or RHC license/certification on file with the Illinois Vaccines for Children program.

**Mark McGranahan, MD – Lori Eberhart, MD – Jean Wagner, MD – Claire Foehrkalb, RN, CPNP**

Does this patient qualify for immunization through the VFC program because he/she:

Check only one box

Yes, in enrolled in Medicaid

Yes, does NOT have health insurance

Yes, is an American Indian or Alaska Native

Yes, is underinsured (had health insurance that does not pay for vaccines)\*

N/A

No, this child does not qualify for immunizations through the VFC program because he/she does not meet the eligibility criteria

\*To be supported with VFC purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC. See question 5 above.

### Eligibility Changes

Date Eligibility Changed	Medicaid	Uninsured	American Indian/ Alaska Native	Underinsured*	Does not meet eligibility criteria

\_\_\_\_\_  
Parent/Guardian Signature



## Tuberculosis (TB) Risk Assessment

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Does your child have a first degree relative or person living in your home with a positive tuberculosis test or who is being treated for tuberculosis? Yes No
2. Has your child travelled outside the country? Yes N
3. If yes, what country? \_\_\_\_\_
4. Is your child a recent immigrant or has he/she been adopted from outside this country? Yes No
5. Does your child have a close contact that is in prison? Yes No
6. Does your child have regular exposure to a nursing home or other long-term care facility? Yes No

Signature of parent/guardian: \_\_\_\_\_

Signature of physician: \_\_\_\_\_