Inverness Dental
314 S Line Ave
Inverness, FL 34452
P: 352-419-4056
F: 888-411-2260

Inverness Medical
300 S Line Ave,
Inverness, FL 34452
P: 352-419-5760
F: 877-209-5265

Lecanto Medical
595 N Lecanto Hwy
Lecanto, FL 34461
P: 352-527-2244
F: 877-275-8781

Ocala
7205 SE Maricamp Rd
Ocala, FL 34472
P: 352-680-7000
F: 877-849-9264

Sumterville
1389 S US Hwy 301
Sumterville, FL 33585
P: 352-793-5900
F: 855-832-3504

Homosassa
7945 S Suncoast Blvd
Suites A & B
Homosassa, FL 34446
P: 352-423-4923
F: 352-423-1468

Hi Parent/Guardian,

Langley Health Services is pleased to be coordinating with the Sumter County School Board to offer vaccines! We will be at your child's school on the following dates:

Location	Date	Time
Wildwood Middle High School	August 5, 2024	8am-11am
South Sumter High School	August 5, 2024	2pm-5pm
Lake Panasoffkee Elementary School	August 8, 2024	8:30am-10:30am
South Sumter Middle School	August 9, 2024	10:30am-1:30pm
Wildwood Elementary School	August 12, 2024	8:30am-11:00am
Wildwood Intermediate School	August 12, 2024	1:30pm-3:30pm
Sumter PREP Academy	August 13, 2024	8:30am-9:30am

If you would like for your child to receive a school or sports physical, please complete School/Sports Physical Consent Form.

Vaccines to be offered include Tdap (tetanus, diphtheria, acellular pertussis), meningococcal ACWY, Hepatitis A, and HPV. The Tdap vaccine is required for all students to enter 7th grade. If you would like for your child to receive any of the vaccines offered, please complete the attached consent form. On the form, in the block under the vaccine name, you will need to initial for each vaccine you consent for your child to receive.

Please bring your completed forms with you on the day of the event.

For your future healthcare needs, keep in mind we offer the following services: medical, dental, behavioral health, radiology (x-rays, MRIs, CT scans, ultrasounds, etc.), podiatry (foot and ankle care), and pharmacy services. We have locations in Sumter, Citrus, and Marion counties. If you have any questions, or need any assistance, please let us know! We will be happy to help you.

Thank you,
Your Langley Health Services team

School/Sports Physical Consent Form

Please complete this form if your child is to receive a physical

Patient's Name (last, first, middle initial):	
Patient's Date of Birth:	Patient's Social Security Number:
Patient Phone Number: ( )	Patient Email:
Patient's Address:	

Patient's Sex (gender assigned at birth):	Patient's Ethnicity:	Patient's Race:	
☐ Female	☐ Hispanic/latino	☐ American Indian/Alaskan Native	☐ Asian
☐ Male	☐ Not Hispanic/latino	☐ Black/African American	☐ Native Hawaiian
	☐ Unknown	☐ Other Pacific Islander	☐ White
	☐ Decline to specify	☐ Unknown	☐ Decline to specify

Student's Insurance screening: **Please complete this section entirely**.

☐ Medicaid ☐ No health insurance ☐ Insured

If student is insured:

Primary Insurance Carrier ID #: _____ Grp #: _____

Insurance Company: _____ Insurance Company Phone #: _____

Insured's Name: _____ Insured's Relationship to Patient: _____ Insured's Date of Birth: _____

Secondary Insurance Carrier ID #: _____ Grp #: _____

Insurance Company: _____ Insurance Company Phone #: _____

Insured's Name: _____ Insured's Relationship to Patient: _____ Insured's Date of Birth: _____

STUDENT'S SCHOOL INFORMATION-

Which school does the student attend?

What grade is the student in?

Who is the student's homeroom teacher?

CONSENTS AND ACKNOWLEDGEMENTS

Consent for Treatment

I hereby give consent and authorize examination and treatment at Project Health, Inc. d/b/a Langley Health Services (LHS) for myself, the patient, by the personnel at LHS. The need for the examination and treatment, and the possibility of undesirable side effects, will be explained by the employees of LHS. I understand there is no guarantee or assurance, as to the results which may be obtained, but normal prudent care will be exercised by employees for LHS concerning my diagnosis and treatment.

Consent for Treatment of a Minor *only complete if patient is under 18 years of age*

I, as the parent or legal guardian of the patient, _____, do hereby give my consent and authorize treatment of my child. Furthermore, I grant permission for the following individuals to authorize Medical Treatment in my absence:

1. _____ **Relationship to patient:**_____
2. _____ **Relationship to patient:**_____
3. _____ **Relationship to patient:**_____

Notice of Privacy Practices

I acknowledge that I have received the practice's Notice of Privacy which describes the ways in which the practice may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Compliance Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy.

Release of Information

Reasons for releasing a patient's record include, but are not limited to:

- Insurance company(ies), their agents or other third party payor and/or
- Government or social service agencies which may or will pay for any part of the medical/hospital expenses incurred or
- Authorized representatives of Langley Health Services as mandated by law or
- Alternate care providers, including community agencies and services, as ordered by patient's provider or

- As requested by Patient or Patient's family for post-hospital care

Patient acknowledges and agrees that some, or all, of the patient's records may be accessible through the patient portal and/or the Health Information Exchange. Patient acknowledges and agrees the patient's records will be available to all Langley Health Services affiliated entities and providers, and to non-Langley affiliated providers in compliance with the provisions of meaningful use.

Patient Rights, Responsibilities and Information and Patient Centered Medical Home

I choose to participate in the Patient-Centered Medical Home. These documents are posted on our website: www.langleymedicalcenter.com. I acknowledge that I have received or have been allowed to view a copy of each and understand and agree to the terms set forth in the policies.

After Hours Non-Emergency Services

Patients have after-hour access to on-call Langley Health Services providers 24 hours a day, seven days a week through an answering service by calling (352) 793-5900. For medication refills, please contact your pharmacy or Langley Health Services during normal business hours. For emergency services, call 911 or go to the nearest hospital emergency room.

Residents, Students and Observers

I understand that Project Health, Inc. d/b/a Langley Health Services (LHS) supports the education of medical professionals and maintains Students that may assist in relation to care. I understand that in accordance with LHS federal regulations & accreditation, as well as educational training, residents, students and observers may be present in patient care areas.

Consent for Use and Disclosure of Protected Health Information (PHI)

Project Health, Inc. d/b/a Langley Health Services (LHS) is committed to ensuring the privacy and confidentiality of your medical information. To assist us in protecting your privacy, please complete the following information:

(Check Yes or No)	Yes	No
May we leave a clinical message if no answer?		
May we leave a billing concern message if no answer?		
May we send an appointment reminder using text messaging? *If yes, what is your cell phone carrier?* _____		
May we send you an email regarding reminders and clinical notes?		

May we leave information with someone other than you regarding your medical care (medication changes, laboratory results, appointments, etc? ☐ Yes (If yes, please list the name(s) in the space(s) below) ☐ No

Name	Relationship	Phone Number

**You have the right to revoke whom we talk with about your health care at anytime. Please complete a new consent.

I understand I may revoke this consent in writing at any time. When the consent is revoked it will only affect my health information from that point on.

By signing below, I verify this information to be true to the best of my ability. Additionally, I agree, understand, and consent to all items in the Consents and Acknowledgements section.

REQUIRED SIGNATURES	
Signature of Patient Parent/Guardian:	Today's Date:
Signature of Langley Health Services' Employee:	Today's Date:

School Vaccine Consent Form

Please complete this form if your child is to receive a vaccine

Please write legibly and complete all blank fields.

Student's Name (last, first, middle initial):	
Student's Date of Birth:	Student's Social Security Number:
Parent/Guardian Phone Number: ( )	Parent/guardian Email:
Student's Address:	

Student's Sex (gender assigned at birth):	Student's Ethnicity:	Student's Race:
☐ Female ☐ Male	☐ Hispanic/latino ☐ Not Hispanic/latino ☐ Unknown	☐ American Indian/Alaskan Native ☐ Black/African American ☐ Other Pacific Islander ☐ Unknown ☐ Asian ☐ Native Hawaiian ☐ White

Student's Insurance screening: **Please complete this section entirely**.

☐ Medicaid ☐ No health insurance ☐ Insured

If student is insured:

Primary Insurance Carrier ID #: _____ Grp #: _____

Insurance Company: _____ Insurance Company Phone #: _____

Insured's Name: _____ Insured's Relationship to Patient: _____ Insured's Date of Birth: _____

Secondary Insurance Carrier ID #: _____ Grp #: _____

Insurance Company: _____ Insurance Company Phone #: _____

Insured's Name: _____ Insured's Relationship to Patient: _____ Insured's Date of Birth: _____

STUDENT'S SCHOOL INFORMATION-

Which school does the student attend?

What grade is the student in?

Who is the student's homeroom teacher?

VACCINE HEALTH SCREENING- Please answer all questions about the student who will be receiving the vaccine(s). You will answer by placing a check mark in the correct "yes" or "no" column. Answers will determine whether the student can be vaccinated at this time**.**

	YES	NO
Is the student to be vaccinated sick today? *Temperature will be taken prior to vaccination*.		
Does the student have any allergies to medication, foods, latex, or any vaccines? If yes, please explain the allergy: _____		
Has the person to be vaccinated ever had a serious reaction to Tdap vaccine in the past?		
Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak?		
Has the child received vaccinations in the past 4 weeks?		

CONSENT TO VACCINATE

I (parent or guardian of student named above) have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for the vaccine(s) my child will be receiving. I understand that for coordination purposes only, this information may be shared with the staff at my child's school and/or the Sumter County School Board. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccines and ask the following vaccine be given to my child on the scheduled school clinic date (**initial all that apply**):

Tetanus, diphtheria, acellular pertussis (Tdap) *Tetanus-diphtheria-pertussis (Tdap) immunization is required for all students entering 7th grade*	**Meningococcal ACWY (MCV4)**	**Hepatitis A**	**HPV**

Printed Name of Parent or Guardian of Patient:	Signature of Parent or Guardian of Patient:	Today's Date:

Patient's Bill of Rights and Responsibilities

This page for your records only- you do not need to bring it with you to the event

PATIENT RIGHTS

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know that rules and regulations apply to his or her conduct.
- A patient has the right to know to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to pain relief.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to provide feedback, whether negative or positive, regarding the service that was received.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate licensing agency.
- A patient has the right to change providers if other qualified providers are available.
- A patient has a right to have his or her prescriptions filled at their pharmacy of choice.
- A patient has the right to information and an explanation regarding the Patient Centered Medical Home approach to care.
- A patient has the right to obtain information and forms related to Advanced Directives (living will and health care surrogate designation).

PATIENT RESPONSIBILITIES

- A patient is responsible for providing complete and accurate information to the best of their ability about their health to the health care provider. Information will include any medications taken, including over-the-counter products and dietary supplements, allergies, sensitivities, present complaints, past illnesses, hospitalizations, and other matters relating to his or her care.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the agreed-upon treatment plan prescribed by the health care provider and participate in their care.
- A patient is responsible to provide a responsible adult to provide transportation home and to remain with patient as directed by the provider or as indicated on discharge instructions.
- A patient is responsible for keeping appointments and, when unable to do so for any reason, for notifying the healthcare provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatments or does not follow the provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for the need to accept personal financial responsibility for any charges not covered by insurance.
- A patient is responsible for following health care facility rules and regulations affecting patient care and to behave respectfully toward all health care professionals and staff, as well as other patients and visitors.
- If participating in the Patient Centered Medical Home, a patient is responsible for talking with his/her team about health questions, sharing past health care successes and challenges, telling the team about other health care professionals that care for him/her, following the health care plan that has been discussed, making sure he/she understands the plan and asks questions if not understanding, telling the team if you are having trouble sticking with the care plan, and speaking up if the care plan is not working so together changes can be made, if needed.

Notice of Privacy Practices
Effective September 30, 2013

This page for your records only- you do not need to bring it with you to the event

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

- **For Care or Treatment**: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*
- **For Payment:** Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*
- **For Business Operations:** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*
- **Required by Law:** Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.
- **Without Authorization**: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:
    - Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
    - Required by Court Order
    - Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Verbal Permission:** We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.
- **With Authorization**: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release

psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

- **Your rights regarding your PHI**
- You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:
    - **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
    - **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
    - **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
    - **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
    - **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
    - **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *LHS.* If you have questions and would like additional information, you may contact us at (352) 793-5900 or toll free at (888) 298-5510.

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.

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

Anyone can get meningococcal disease. Certain people are at increased risk, including:

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

2. Meningococcal ACWY vaccine

Adolescents need 2 doses of a meningococcal ACWY vaccine:

- First dose: 11 or 12 years of age
- Second (booster) dose: 16 years of age

In addition to routine vaccination for adolescents, meningococcal ACWY vaccine is also recommended for **certain groups of people**:

- People at risk because of a serogroup A, C, W, or Y meningococcal disease outbreak
- People with HIV
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called "complement component deficiency"
- Anyone taking a type of drug called a "complement inhibitor," such as eculizumab (also called "Soliris"®) or ravulizumab (also called "Ultomiris"®)
- Microbiologists who routinely work with isolates of *N. meningitidis*
- Anyone traveling to or living in a part of the world where meningococcal disease is common, such as parts of Africa
- College freshmen living in residence halls who have not been completely vaccinated with meningococcal ACWY vaccine
- U.S. military recruits

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

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

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

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

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

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

Your health care provider can give you more information.

4. Risks of a vaccine reaction

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

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

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

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

7. How can I learn more?

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

Hepatitis A 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?

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

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

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

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

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

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

2. Hepatitis A vaccine

Children need 2 doses of hepatitis A vaccine:
- First dose: 12 through 23 months of age
- Second dose: at least 6 months after the first dose

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

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

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

Hepatitis A vaccine is also recommended for the following people:
- International travelers
- Men who have sexual contact with other men
- People who use injection or non-injection drugs
- People who have occupational risk for infection
- People who anticipate close contact with an international adoptee
- People experiencing homelessness
- People with HIV
- People with chronic liver disease

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

Hepatitis A vaccine may be given at the same time as other vaccines.

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

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

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

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

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

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

Your health care provider can give you more information.

4. Risks of a vaccine reaction

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

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

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

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

7. How can I learn more?

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

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
- anal cancers in both men and women
- cancers of tonsils, base of tongue, and back of throat (oropharyngeal cancer) in both men and women

HPV infections can also cause anogenital warts.

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

HPV is spread through intimate skin-to-skin or sexual contact. HPV infections are so common that nearly all people will get at least one type of HPV at some time in their lives. Most HPV infections go away on their own within 2 years. But sometimes HPV infections will last longer and can cause cancers later in life.

2. HPV vaccine

HPV vaccine is routinely recommended for adolescents at 11 or 12 years of age to ensure they are protected before they are exposed to the virus. HPV vaccine may be given beginning at age 9 years and vaccination is recommended for everyone through 26 years of age.

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

Most children who get the first dose before 15 years of age need 2 doses of HPV vaccine. People who get the first dose at or after 15 years of age and younger people with certain immunocompromising conditions need 3 doses. Your health care provider can give you more information.

HPV vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of HPV vaccine**, or has any **severe, life-threatening allergies**
- Is **pregnant**—HPV vaccine is not recommended until after pregnancy

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

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

Your health care provider can give you more information.

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 can happen after HPV vaccination.
- Fever or headache can happen after HPV vaccination.

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

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

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.

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

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

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

1. Why get vaccinated?

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

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

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

2. Tdap vaccine

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

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

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

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

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

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

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

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

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

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

Your health care provider can give you more information.

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

4. Risks of a vaccine reaction

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

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

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

5. What if there is a serious problem?

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