

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

4 YEAR VISIT

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? No Yes, describe:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs? No Yes, describe:

Have there been major changes lately in your child's or family's life? No Yes, describe:

Have any of your child's relatives developed new medical problems since your last visit? No Yes Unsure If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? No Yes Unsure

YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior? No Yes, describe:

Check off each of the tasks that your child is able to do.

- | | | |
|--|---|---|
| <input type="checkbox"/> Go to the bathroom and have a bowel movement by himself. | <input type="checkbox"/> Speak so strangers can understand 100% of what she says. | <input type="checkbox"/> Climb stairs, using one foot, then the other, without support. |
| <input type="checkbox"/> Dress and undress without much help. | <input type="checkbox"/> Draw pictures you recognize. | <input type="checkbox"/> Draw a person with at least 3 body parts. |
| <input type="checkbox"/> Play make-believe. | <input type="checkbox"/> Follow simple rules when playing board or card games. | <input type="checkbox"/> Draw a simple cross. |
| <input type="checkbox"/> Answer questions such as "What do you do when you are cold?" and "When you are sleepy?" | <input type="checkbox"/> Tell you a story from a book. | <input type="checkbox"/> Unbutton and button medium-sized buttons. |
| <input type="checkbox"/> Use 4-word sentences. | <input type="checkbox"/> Skip on one foot. | <input type="checkbox"/> Grasp a pencil with a thumb and fingers instead of her fist. |

Please print.

4 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Lead	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your child have a dentist?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Tuberculosis	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security		
Is permanent housing a worry for you?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have enough heat, hot water, electricity, and working appliances?	<input type="radio"/> Yes	<input type="radio"/> No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	<input type="radio"/> No	<input type="radio"/> Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	<input type="radio"/> No	<input type="radio"/> Yes
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	<input type="radio"/> No	<input type="radio"/> Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	<input type="radio"/> No	<input type="radio"/> Yes
Intimate Partner Violence		
Do you always feel safe in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or your child?	<input type="radio"/> No	<input type="radio"/> Yes
Safety in the Community		
Do you feel safe in your community?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have someone you can turn to if you are concerned about your child's safety?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have connections to your community through faith groups, volunteer organizations, or recreational programs?	<input type="radio"/> Yes	<input type="radio"/> No
Do you spend time with parents of other children in your community?	<input type="radio"/> Yes	<input type="radio"/> No

GETTING READY FOR SCHOOL

Language Understanding and Fluency		
Does your child clearly communicate his wants and needs to you and others?	<input type="radio"/> Yes	<input type="radio"/> No
Do you respond to your child's questions with short and simple answers?	<input type="radio"/> Yes	<input type="radio"/> No
Do you give your child plenty of time to tell a story or answer a question?	<input type="radio"/> Yes	<input type="radio"/> No
Do you talk, sing, and read together every day?	<input type="radio"/> Yes	<input type="radio"/> No

4 YEAR VISIT

GETTING READY FOR SCHOOL (CONTINUED)

Feelings		
Is your child generally happy and active?	<input type="radio"/> Yes	<input type="radio"/> No
Do you help your child say, "I'm sorry," for hurting others' feelings?	<input type="radio"/> Yes	<input type="radio"/> No
Opportunities to Socialize With Other Children		
Is your child interested in other children?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have a chance to play with other children in playgroups or at preschool?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have a best friend?	<input type="radio"/> Yes	<input type="radio"/> No
Do you praise your child when she is good or has finished a task?	<input type="radio"/> Yes	<input type="radio"/> No
Early Childhood Programs and Preschool		
Does your child attend preschool?	<input type="radio"/> Yes	<input type="radio"/> No
Are you happy with your child care or preschool arrangement?	<input type="radio"/> Yes	<input type="radio"/> No
Do you visit your child's preschool and participate in activities there?	<input type="radio"/> Yes	<input type="radio"/> No
Readiness for School		
Do you have any concerns about your child starting school in the coming year?	<input type="radio"/> No	<input type="radio"/> Yes
Are you doing things to get your child ready for preschool? This could include reading together and going to the library, the park, the zoo, and other places.	<input type="radio"/> Yes	<input type="radio"/> No

HEALTHY HABITS

Nutrition		
Does your child drink water every day?	<input type="radio"/> Yes	<input type="radio"/> No
How many ounces of milk does your child drink on most days?	_____ oz	
Do you offer your child a variety of foods, including vegetables, fruits, and foods rich in protein, such as meat, eggs, chicken, or fish?	<input type="radio"/> Yes	<input type="radio"/> No
Is your child willing to try new flavors and food textures?	<input type="radio"/> Yes	<input type="radio"/> No
Do you let your child decide how much to eat and when to stop?	<input type="radio"/> Yes	<input type="radio"/> No
Daily Routines That Promote Health		
Does your child sleep well?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a regular bedtime and mealtime routines?	<input type="radio"/> Yes	<input type="radio"/> No
Do you brush your child's teeth twice a day with a pea-sized amount of fluoridated toothpaste?	<input type="radio"/> Yes	<input type="radio"/> No

LIMITING TV AND PROMOTING PHYSICAL ACTIVITY

How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	
Does your child have a TV or an Internet-connected device in her bedroom?	<input type="radio"/> No	<input type="radio"/> Yes
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child play actively for at least 1 hour a day?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child play with other children?	<input type="radio"/> Yes	<input type="radio"/> No
Are you physically active together as a family, such as going for walks or playing in the park?	<input type="radio"/> Yes	<input type="radio"/> No

SAFETY

Car Safety		
Is your child fastened securely in a car safety seat or belt-positioning booster seat in the back seat every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone else in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

4 YEAR VISIT

SAFETY (CONTINUED)

Outdoor Safety		
Do you watch your child closely when she plays outside, especially near streets and driveways?	<input type="radio"/> Yes	<input type="radio"/> No
Are there swimming pools in your neighborhood?	<input type="radio"/> No	<input type="radio"/> Yes
Are you planning to have your child learn to swim?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child always wear an US Coast Guard–approved life jacket when on a boat?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child always use sunscreen when he plays outside?	<input type="radio"/> Yes	<input type="radio"/> No
Pets		
Do you own a pet?	<input type="radio"/> No	<input type="radio"/> Yes
Have you taught your child how to behave around animals so she does not get bitten or scratched?	<input type="radio"/> Yes	<input type="radio"/> No
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	<input type="radio"/> No	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition*

For more information, go to <https://brightfutures.aap.org>.





Patient Information Form

	Today's Date _____
Child's Name _____	Birthdate _____ Sex <u> </u> M / F
Address _____ Zip Code _____ Social Security # _____	
Name & birthdates of child's brothers and/or sisters (include last name if different) _____ _____	
Has your child ever been seen at our practice? <input type="checkbox"/> NO <input type="checkbox"/> YES When? _____	
Have any of your child's brothers and/or sisters ever been seen at our practice? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, which brothers or sisters? _____	
If your child (or children) has not been seen before, who may we thank for referring you to our office? _____	
Name of child's previous doctor _____	
Name of parents' family doctor _____	
Name of mother's obstetrician/gynecologist _____	
How did you hear about SPC? <input type="checkbox"/> Physician / Hospital <input type="checkbox"/> Marketing Ads <input type="checkbox"/> Social Media (Facebook / Instagram) <input type="checkbox"/> Google <input type="checkbox"/> SPC's Website <input type="checkbox"/> Patient <input type="checkbox"/> Signage (building) <input type="checkbox"/> Related Profession (Physical Therapy etc.): _____ <input type="checkbox"/> Other: _____	

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____	Birthdate _____
Social Security # _____	Marital Status _____ Email _____
Address _____ Home Phone _____	
Employer _____	Occupation _____ Work Phone _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____	Birthdate _____
Social Security # _____	Marital Status _____ Email _____
Address _____ Home Phone _____	
Employer _____	Occupation _____ Work Phone _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD		
Primary Policy Holder Name	Primary Insurance	Secondary Ins./Medicaid

EMERGENCY CONTACT OTHER THAN PARENT Name _____
Relationship _____ Address _____ Home Phone _____

I authorize Dr. Blache to release any medical information necessary to process an insurance claim for my son/daughter _____ and request the insurance company to make payment to Dr. Blache . I also authorize Southern Pediatric Clinic, LLC staff and/or Dr. Blache to use the contact information listed above.		
Parent/Guardian Printed Name	Signature	Date



Financial Consent

1. **ASSIGNMENT OF BENEFITS/BILLING AUTHORIZATION CONSENT:**

- Private Insurance: The cost of our services will be billed to your insurance company. If your private insurance denies coverage, or does not pay within 90 days of billing, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).
- Private Pay: You are financially responsible of all fees due at time of service. The amount of fees for services may vary depending on changes in the patient's medical condition, progress, and physician order(s).
- State Insurance: The cost of our services will be billed to your insurance company. If your state insurance denies coverage, or retro disenrolls the patient, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).
- For those families where parents are separated or divorced, the parent who brings the child or children to the office visit and authorizes treatment is responsible for payment(s). Payments are due when services are rendered. If the divorced/custodial decree makes the non-custodial parent/guardian responsible for partial or all medical costs, it will be the responsibility of the authorizing parent to collect payment from the other parent.

2. **NOTICE OF PATIENT RESPONSIBILITY FOR CO-PAYS, PERCENTAGES & DEDUCTIBLES:**

Southern Pediatric Clinic will attempt to verify your insurance benefits and eligibility. The information we receive is based on the information you and your insurance company provide to us. As a courtesy, we will bill your insurance company for their portion of your bill. Ultimately it is your responsibility to see that we are paid appropriately by your insurance company. If the information given to us by you or your insurance company proves to be inaccurate and a balance remains, you will be billed for that balance and are responsible for payment within thirty (30) days unless you set up a payment plan with our billing specialists.

BY SIGNING BELOW, YOU INDICATE THAT:

1. You agree with the provisions of the payment source as described above. You understand that if you accept the services we have provided, you are ultimately responsible for payment. Should it be necessary to use collection services, any additional fees will also be your responsibility.
2. You authorize payment of any insurance benefits directly to Southern Pediatric Clinic.
3. You authorize the release of medical information to and from Southern Pediatric Clinic.
4. You agree to pay all co-pays, percentages, and deductibles at the time of service.

Patient Name	Date of Birth
Responsible Party Name and Signature	Today's Date

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF INSURANCE CARD(S)

Primary Policy Holder Name	Primary Insurance	Primary Insurance Policy Number										
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; border: 1px solid black; text-align: center;">M</td> <td style="width: 10%; border: 1px solid black; text-align: center;">F</td> <td style="width: 10%; border: 1px solid black;"></td> <td style="width: 10%; border: 1px solid black;"></td> <td style="width: 10%; border: 1px solid black;"></td> <td style="width: 10%; border: 1px solid black;"></td> <td style="width: 10%; border: 1px solid black;"></td> <td style="width: 10%; border: 1px solid black;"></td> <td style="width: 10%; border: 1px solid black;"></td> <td style="width: 10%; border: 1px solid black;"></td> </tr> </table>	M	F									Secondary Ins./Medicaid	Secondary Ins./Medicaid Policy Number
M	F											

Office Staff Initials



**Consent & Disclosure of PHI & Treatment of Patient &
 Statement of Persons Allowed to Accompany Patient to Office Visits**

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

Patient's Name: _____ Date of Birth: _____

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Southern Pediatric Clinic, LLC and employees., may use and disclose PHI about the said patient above to carry out treatment, payment and healthcare operations (TPO). Please review the Notice of Privacy Practices for full information regarding this statement.

1. I have reviewed the Notice of Privacy Practices for Southern Pediatric Clinic and I acknowledge that Southern Pediatric Clinic has the right to revise its Notice of Privacy Practices at any time and that I will have access to revisions.
2. I have read and understand the Notices of Privacy Practices that are in place and that I may contact the Privacy Officer listed for further questions.
3. Southern Pediatric Clinic, and all those associated, may call my home or other designated location and leave a message on voice mail or in person in reference that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
4. Southern Pediatric Clinic may treat my child and order diagnostic tests and labs for diagnosis and treatment.
5. Southern Pediatric Clinic may disclose Individually Identifiable Health Information (IIHI) that will be used to carry out TPO as referred to above, to anyone specified below who brings my child(ren) to the office for treatment.
6. Southern Pediatric Clinic will not act as mediator in separation, divorced, and/or custody battles. We must abide by the laws set forth in court-ordered documents for your child. Please make sure we have a copy on file.

DUE TO HIPAA REQUIREMENTS, PATIENTS CAN ONLY BE ACCOMPANIED TO OFFICE VISITS BY PARENTS, LEGAL GUARDIANS OR PERSONS WHOSE NAMES ARE DOCUMENTED IN THE PATIENT'S CHART. PLEASE INDICATE BELOW FOR BOTH IIHI AND HIPPA COMPLIANCE.

Name	Relationship to Patient	Disclose PHI		Accompany to Appointment	
		<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no

I have the right to request that Southern Pediatric Clinic restricts how it uses or discloses my PHI to carry out TPO. However, the practices are not required to agree to my requested restrictions, but if it doesn't, it is bound by this agreement. By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that which the practice has already made disclosures upon my prior consent. If I do not sign this consent, providers for Southern Pediatric Clinic may decline to provide treatment for my child(ren).

 Signature of Parent/Guardian

 Date

 Printed Name of Parent/Guardian



Child's Name _____

DOB _____

CELL PHONE USE POLICY

The purpose of this policy is to outline the acceptable use of cellular phone (“cellphones”) and other communication devices, including but not limited to, mobiles phones, iPhones, iPads, iPods, tablets, or any other wireless device (collectively referred to as “communication devices”) at *Southern Pediatric Clinic, LLC*. These rules are in place to protect the workers and *Southern Pediatric Clinic, LLC*, along with the privacy of each of our patients. Inappropriate use of communication devices may harm others within the office by violating HIPAA laws and regulations.

1. **Who this Policy Applies To:**

This Policy applies to patients that are being seen within the office and their family members.

2. **What devices this Policy Applies To: (Video recording or pictures during vaccinations is PROHIBITED)**

- a. All devices that can be used for recording.
- b. All devices that can be used for communicating with others.
- c. All devices that may hinder the quality of care the patient may receive.

3. **Permitted Use:**

The devices mentioned can be used in the lobby if needed. However, it is recommended that the patient or family members be conscious of others that may be in the lobby.

4. **Violations of This Policy:**

Patients or family members that violate this policy may be asked to leave and are subject to dismissal depending on circumstances.

I have read and will abide by the terms of this policy regarding the use of communication devices in this office.

Signature of Parent/Guardian or Patient _____

Date _____



PATIENT

Last Name	First Name	MI	Date of Birth
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PARENT/GUARDIAN

Last Name	First Name	MI
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Patient Eligibility Screening Record

Vaccines for Children Program

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider’s office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record may be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits as long as 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(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of \$21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child...		
(A) is enrolled in Medicaid (PeachState, WellCare, AmeriGroup, CareSource or SSI Medicaid).	<input type="radio"/>	OR
(B) is American Indian or Alaskan Native.	<input type="radio"/>	OR
(C) does not have health insurance.	<input type="radio"/>	OR
(D) has health insurance that does not pay for vaccines.	<input type="radio"/>	OR
(E) is enrolled in PeachCare (PeachCare will be listed as Managed Care Provider).	<input type="radio"/>	OR
(F) has health insurance that pays for vaccines.	<input type="radio"/>	

Parent/Guardian Name (print)

Signature

Date

DTaP (Diphtheria, Tetanus, 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?

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

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

- **DIPHThERIA (D)** can lead to difficulty breathing, heart failure, paralysis, or death.
- **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.
- **PERTUSSIS (aP)**, also known as “whooping cough,” can cause uncontrollable, violent coughing which makes it hard to breathe, eat, or drink. Pertussis can be extremely serious 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 DTaP vaccine

DTaP is only for children younger than 7 years old. Different vaccines against tetanus, diphtheria, and pertussis (Tdap and Td) are available for older children, adolescents, and adults.

It is recommended that children receive 5 doses of DTaP, usually at the following ages:

- 2 months
- 4 months
- 6 months
- 15–18 months
- 4–6 years

DTaP may be given as a stand-alone vaccine, or as part of a combination vaccine (a type of vaccine that combines more than one vaccine together into one shot).

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

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of 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 or DTaP)**.
- 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 child’s health care provider may decide to postpone DTaP vaccination to a future visit.

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

Your child’s health care provider can give you more information.



4 Risks of a vaccine reaction

- Soreness or swelling where the shot was given, fever, fussiness, feeling tired, loss of appetite, and vomiting sometimes happen after DTaP vaccination.
- More serious reactions, such as seizures, non-stop crying for 3 hours or more, or high fever (over 105°F) after DTaP vaccination happen much less often. Rarely, the vaccine is followed by swelling of the entire arm or leg, especially in older children when they receive their fourth or fifth dose.
- Very rarely, long-term seizures, coma, lowered consciousness, or permanent brain damage may happen after DTaP vaccination.

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

5 What if there is a serious problem?

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

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

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

6 The National Vaccine Injury Compensation Program

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

7 How can I learn more?

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

Vaccine Information Statement (Interim)
DTaP (Diphtheria, Tetanus,
Pertussis) Vaccine



Office use only

04/01/2020 | 42 U.S.C. § 300aa-26

MMRV Vaccine (Measles, Mumps, Rubella, and Varicella): *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?

MMRV vaccine can prevent **measles, mumps, rubella, and varicella.**

- **MEASLES (M)** can cause fever, cough, runny nose, and red, watery eyes, commonly followed by a rash that covers the whole body. It can lead to seizures (often associated with fever), ear infections, diarrhea, and pneumonia. Rarely, measles can cause brain damage or death.
- **MUMPS (M)** can cause fever, headache, muscle aches, tiredness, loss of appetite, and swollen and tender salivary glands under the ears. It can lead to deafness, swelling of the brain and/or spinal cord covering, painful swelling of the testicles or ovaries, and, very rarely, death.
- **RUBELLA (R)** can cause fever, sore throat, rash, headache, and eye irritation. It can cause arthritis in up to half of teenage and adult women. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects.
- **VARICELLA (V)**, also called chickenpox, can cause an itchy rash, in addition to fever, tiredness, loss of appetite, and headache. It can lead to skin infections, pneumonia, inflammation of the blood vessels, swelling of the brain and/or spinal cord covering, and infection of the blood, bones, or joints. Some people who get chickenpox get a painful rash called shingles (also known as herpes zoster) years later.

Most people who are vaccinated with MMRV will be protected for life. Vaccines and high rates of vaccination have made these diseases much less common in the United States.

2 MMRV vaccine

MMRV vaccine may be given to **children 12 months through 12 years of age**, usually:

- First dose at 12 through 15 months of age
- Second dose at 4 through 6 years of age

MMRV vaccine may be given at the same time as other vaccines. Instead of MMRV, some children might receive separate shots for MMR (measles, mumps, and rubella) and varicella. Your health care provider can give you more information.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of MMRV, MMR, or varicella vaccine**, or has any **severe, life-threatening allergies.**
- Is **pregnant**, or thinks she might be pregnant.
- Has a **weakened immune system**, or has a **parent, brother, or sister with a history of hereditary or congenital immune system problems.**
- Has ever had a **condition that makes him or her bruise or bleed easily.**
- Has a **history of seizures**, or has a **parent, brother, or sister with a history of seizures.**
- Is **taking, or plans to take salicylates** (such as aspirin).
- Has recently **had a blood transfusion or received other blood products.**
- Has **tuberculosis.**
- Has **gotten any other vaccines in the past 4 weeks.**

In some cases, your health care provider may decide to postpone MMRV vaccination to a future visit, or may recommend that the child receive separate MMR and varicella vaccines instead of MMRV.



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

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- Soreness, redness, or rash where the shot is given can happen after MMRV vaccine.
- Fever or swelling of the glands in the cheeks or neck sometimes occur after MMRV vaccine.
- Seizures, often associated with fever, can happen after MMRV vaccine. The risk of seizures is higher after MMRV than after separate MMR and varicella vaccines when given as the first dose of the series in younger children. Your health care provider can advise you about the appropriate vaccines for your child.
- More serious reactions happen rarely. These can include pneumonia, swelling of the brain and/or spinal cord covering, or temporary low platelet count which can cause unusual bleeding or bruising.
- In people with serious immune system problems, this vaccine may cause an infection which may be life-threatening. People with serious immune system problems should not get MMRV vaccine.

It is possible for a vaccinated person to develop a rash. If this happens, it could be related to the varicella component of the vaccine, and the varicella vaccine virus could be spread to an unprotected person. Anyone who gets a rash should stay away from people with a weakened immune system and infants until the rash goes away. Talk with your health care provider to learn more.

Some people who are vaccinated against chickenpox get shingles (herpes zoster) years later. This is much less common after vaccination than after chickenpox disease.

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

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

5 What if there is a serious problem?

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

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

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

6 The National Vaccine Injury Compensation Program

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

7 How can I learn more?

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

Vaccine Information Statement (Interim)
MMRV Vaccine



Office use only

Polio 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?

Polio vaccine can prevent **polio**.

Polio (or poliomyelitis) is a disabling and life-threatening disease caused by poliovirus, which can infect a person's spinal cord, leading to paralysis.

Most people infected with poliovirus have no symptoms, and many recover without complications. Some people will experience sore throat, fever, tiredness, nausea, headache, or stomach pain.

A smaller group of people will develop more serious symptoms that affect the brain and spinal cord:

- Paresthesia (feeling of pins and needles in the legs),
- Meningitis (infection of the covering of the spinal cord and/or brain), or
- Paralysis (can't move parts of the body) or weakness in the arms, legs, or both.

Paralysis is the most severe symptom associated with polio because it can lead to permanent disability and death.

Improvements in limb paralysis can occur, but in some people new muscle pain and weakness may develop 15 to 40 years later. This is called post-polio syndrome.

Polio has been eliminated from the United States, but it still occurs in other parts of the world. The best way to protect yourself and keep the United States polio-free is to maintain high immunity (protection) in the population against polio through vaccination.

2 Polio vaccine

Children should usually get 4 doses of polio vaccine, at 2 months, 4 months, 6–18 months, and 4–6 years of age.

Most **adults** do not need polio vaccine because they were already vaccinated against polio as children. Some adults are at higher risk and should consider polio vaccination, including:

- people traveling to certain parts of the world,
- laboratory workers who might handle poliovirus, and
- health care workers treating patients who could have polio.

Polio vaccine may be given as a stand-alone vaccine, or as part of a combination vaccine (a type of vaccine that combines more than one vaccine together into one shot).

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

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

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

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



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

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- A sore spot with redness, swelling, or pain where the shot is given can happen after polio vaccine.

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