PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
12 MONTH 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.

- ☐ Look for hidden objects.
- ☐ Imitate new gestures.
- ☐ Say, "Dad" or "Mom" with meaning
- ☐ Use one word other than *Mom*, *Dad*, or personal names.
- ☐ Follow a verbal command that includes a gesture.
- ☐ Take first independent steps.
- ☐ Stand without support.
- ☐ Drop objects in a cup.
- ☐ Pick up small object with 2-finger pincer grasp.
- ☐ Pick up food and eat it.

PATIENT NAME: _____ DATE: _____

Please print.

12 MONTH VISIT

RISK ASSESSMENT

Hearing	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
	Do you have concerns about how your child speaks?	O No	O Yes	O 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 that was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your child's primary water source contain fluoride?	O Yes	O No	O 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)?	O No	O Yes	O Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
	Is your child infected with HIV?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
	Do your child's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your child's eyes ever been injured?	O No	O Yes	O 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		
Do you have enough heat, hot water, electricity, and working appliances in your home?	O Yes	O No
Do you have problems with bugs, rodents, peeling paint or plaster, mold, or dampness?	O No	O Yes
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	O No	O Yes
Social Connections With Family, Friends, Child Care, Home Visitation Program Staff, and Others		
Do you have child care or an adult you trust to care for your child?	O Yes	O No
Have you talked about your thoughts on feeding, sleeping, discipline, and media use with your caregiver?	O Yes	O No
Do you participate in activities outside your home? These may be social, religious, volunteer, or recreational programs.	O Yes	O No

CARING FOR YOUR CHILD

If your child is upset, do you help distract him using another activity, book, or toy?	O Yes	O No
Do you use time-outs as a way to manage your child's behavior?	O Yes	O No
Do you have any questions about what to do when you become angry or frustrated with your child?	O No	O Yes
Does your family regularly make time for reading, playing, and talking together?	O Yes	O No
Do you eat together as a family?	O Yes	O No
Do you have regular mealtimes and snack times?	O Yes	O No
Do you help your child feel comfortable around new people and new situations?	O Yes	O No
Do you have regular nap time and bedtime routines for your child, such as reading books and brushing teeth?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

12 MONTH VISIT

CARING FOR YOUR CHILD (*CONTINUED*)

Does your child watch TV or play on a tablet or smartphone? If yes, how much time each day? ____ hours	O No	O Yes
Have you made a family media use plan to help you balance media use with other family activities?	O Yes	O No

FEEDING YOUR CHILD

Does your child try feeding herself using a spoon?	O Yes	O No
Does your child drink from a cup?	O Yes	O No
Do you give your child small, hard foods such as peanuts and popcorn?	O No	O Yes
Do you give your child round foods such as hot dogs, raw carrots, grapes, and grape tomatoes?	O No	O Yes
Do you include your child in family meals?	O Yes	O No
Have you begun to serve your child cow's milk?	O Yes	O No
Does your child eat vegetables and fruits?	O Yes	O No
Does your child eat foods rich in protein, such as eggs, lean meat, chicken, or fish?	O Yes	O No
Do you let your child decide what and how much to eat?	O Yes	O No

HEALTHY TEETH

Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day using a soft toothbrush?	O Yes	O No

SAFETY

Car and Home Safety			
Is your child fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?		O Yes	O No
Are you having any problems using your car safety seat?		O No	O Yes
Do you have a gate at the top and bottom of all stairs in your home?		O Yes	O No
Is the mattress in your child's crib set on the lowest setting to prevent falls?		O Yes	O No
Do you keep household cleaners, chemicals, and medicines locked up and out of your child's sight and reach?		O Yes	O No
Do all your electrical outlets have covers?		O Yes	O No
Do you keep sharp objects, plastic bags, and electrical or drapery cords out of your child's reach?		O Yes	O No
Do you keep your child away from the stove, fireplaces, and space heaters?		O Yes	O No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?		O Yes	O No
Water and Sun Safety			
Do you always stay within arm's reach of your child when he is in the bath?		O Yes	O No
Do you have a swimming pool, pond, or lake in or near your home?		O No	O Yes
Do you put a hat on your child and apply sunscreen on her when you go outside?		O Yes	O No
Pets			
Do you own a pet?		O No	O Yes
If so, does your child interact with the pet?	O NA	O No	O Yes

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

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

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
Kereese Gayle-Farias, M.D.
Pediatrics and Adolescent Medicine

406-M Northside Drive
Valdosta, GA 31602
Ph. 229 • 241 • 0059
Fax 229 • 241 • 2088

Patient Information Form

Today's Date _____

Child's Name _____ Birthdate _____ Sex 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? ☐ NO ☐ YES When? _____

Have any of your child's brothers and/or sisters ever been seen at our practice? ☐ YES ☐ 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?
□Physician / Hospital □Marketing Ads □ Social Media (Facebook / Instagram)
□ Google □ SPC's Website □ Patient □ Signage (building)
□ Related Profession (Physical Therapy etc.):_____
□ 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

Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
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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
M F		
Primary Policy Sex / Date of Birth	Secondary Ins./Medicaid	Secondary Ins./Medicaid Policy Number

_____
Office Staff Initials

Southern Pediatric Clinic, LLC
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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
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ 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 my 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

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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

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PATIENT

Last Name	First Name	MI	Date of Birth

PARENT/GUARDIAN

Last Name	First Name	MI

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 my 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 s 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 (Peach**State**, WellCare, AmeriGroup, CareSource or SSI Medicaid).	◯	OR
(B) is American Indian or Alaskan Native.	◯	OR
(C) does not have health insurance.	◯	OR
(D) has health insurance that does not pay for vaccines.	◯	OR
(E) is enrolled in PeachCare (Peach**Care** will be listed as Managed Care Provider).	◯	OR
(F) has health insurance that pays for vaccines.	◯	

.

Parent/Guardian Name (print) Signature Date

Varicella (Chickenpox) 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?

Varicella vaccine can prevent **chickenpox**.

Chickenpox can cause an itchy rash that usually lasts about a week. It can also cause fever, tiredness, loss of appetite, and headache. It can lead to skin infections, pneumonia, inflammation of the blood vessels, and swelling of the brain and/or spinal cord covering, and infections of the bloodstream, bone, or joints. Some people who get chickenpox get a painful rash called shingles (also known as herpes zoster) years later.

Chickenpox is usually mild but it can be serious in infants under 12 months of age, adolescents, adults, pregnant women, and people with a weakened immune system. Some people get so sick that they need to be hospitalized. It doesn't happen often, but people can die from chickenpox.

Most people who are vaccinated with 2 doses of varicella vaccine will be protected for life.

2 Varicella vaccine

Children need 2 doses of varicella vaccine, usually:
- First dose: 12 through 15 months of age
- Second dose: 4 through 6 years of age

Older children, adolescents, and **adults** also need 2 doses of varicella vaccine if they are not already immune to chickenpox.

Varicella vaccine may be given at the same time as other vaccines. Also, a child between 12 months and 12 years of age might receive varicella vaccine together with MMR (measles, mumps, and rubella) vaccine in a single shot, known as MMRV. 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 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**.
- **Is taking 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 varicella 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 varicella vaccine.

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- Sore arm from the injection, fever, or redness or rash where the shot is given can happen after varicella vaccine.
- More serious reactions happen very rarely. These can include pneumonia, infection of the brain and/or spinal cord covering, or seizures that are often associated with fever.
- In people with serious immune system problems, this vaccine may cause an infection which may

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

be life-threatening. People with serious immune system problems should not get varicella vaccine.

It is possible for a vaccinated person to develop a rash. If this happens, 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

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 is a serious liver disease. It is caused by the hepatitis A virus (HAV). HAV is spread from person to person through contact with the feces (stool) of people who are infected, which can easily happen if someone does not wash his or her hands properly. You can also get hepatitis A from food, water, or objects contaminated with HAV.

Symptoms of hepatitis A can include:

- fever, fatigue, loss of appetite, nausea, vomiting, and/or joint pain
- severe stomach pains and diarrhea (mainly in children), or
- jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements).

These symptoms usually appear 2 to 6 weeks after exposure and usually last less than 2 months, although some people can be ill for as long as 6 months. If you have hepatitis A you may be too ill to work.

Children often do not have symptoms, but most adults do. You can spread HAV without having symptoms.

Hepatitis A can cause liver failure and death, although this is rare and occurs more commonly in persons 50 years of age or older and persons with other liver diseases, such as hepatitis B or C.

Hepatitis A vaccine can prevent hepatitis A. Hepatitis A vaccines were recommended in the United States beginning in 1996. Since then, the number of cases reported each year in the U.S. has dropped from around 31,000 cases to fewer than 1,500 cases.

2 Hepatitis A vaccine

Hepatitis A vaccine is an inactivated (killed) vaccine. You will need **2 doses** for long-lasting protection. These doses should be given at least 6 months apart.

Children are routinely vaccinated between their first and second birthdays (12 through 23 months of age). Older children and adolescents can get the vaccine after 23 months. Adults who have not been vaccinated previously and want to be protected against hepatitis A can also get the vaccine.

You should get hepatitis A vaccine if you:

- are traveling to countries where hepatitis A is common,
- are a man who has sex with other men,
- use illegal drugs,
- have a chronic liver disease such as hepatitis B or hepatitis C,
- are being treated with clotting-factor concentrates,
- work with hepatitis A-infected animals or in a hepatitis A research laboratory, or
- expect to have close personal contact with an international adoptee from a country where hepatitis A is common

Ask your healthcare provider if you want more information about any of these groups.

There are no known risks to getting hepatitis A vaccine at the same time as other vaccines.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of hepatitis A vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Ask your health care provider if you want information about vaccine components.
- **If you are not feeling well.** If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

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

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get hepatitis A vaccine do not have any problems with it.

Minor problems following hepatitis A vaccine include:
- soreness or redness where the shot was given
- low-grade fever
- headache
- tiredness

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Your doctor can tell you more about these reactions.

Other problems that could happen after this vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your provider if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get shoulder pain that can be more severe and longer lasting than the more routine soreness that can follow injections. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

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

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious problem?

What should I look for?

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

  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 to the nearest hospital. Otherwise, call your clinic.

  Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does 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.

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**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- 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**

MMR Vaccine (Measles, Mumps, and Rubella): *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?

MMR vaccine can prevent **measles, mumps,** and **rubella**.

- **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.

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

2 MMR vaccine

Children need 2 doses of MMR vaccine, usually:

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

Infants who will be traveling outside the United States when they are between 6 and 11 months of age should get a dose of MMR vaccine before travel. The child should still get 2 doses at the recommended ages for long-lasting protection.

Older children, adolescents, and **adults** also need 1 or 2 doses of MMR vaccine if they are not already immune to measles, mumps, and rubella. Your health care provider can help you determine how many doses you need.

A third dose of MMR might be recommended in certain mumps outbreak situations.

MMR vaccine may be given at the same time as other vaccines. Children 12 months through 12 years of age might receive MMR vaccine together with varicella vaccine in a single shot, known as MMRV. 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 MMR or MMRV 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 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 MMR 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 MMR 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 rash where the shot is given and rash all over the body can happen after MMR vaccine.
- Fever or swelling of the glands in the cheeks or neck sometimes occur after MMR vaccine.
- More serious reactions happen rarely. These can include seizures (often associated with fever), temporary pain and stiffness in the joints (mostly in teenage or adult women), 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 MMR vaccine.

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

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

5 What if there is a serious problem?

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

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

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

6 The National Vaccine Injury Compensation Program

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

7 How can I learn more?

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