Inspiring Growth in Knowledge and Faith

Incoming senior parent/guardian of 2016-2017 Academic year,

This notice is to inform and clarify information about the new Meningococcal Vaccine Requirements. House Bill 3190 was signed into law as Public Act 098-0480. In accordance with requirements of Public Act 90-0607, the State Board of Health is required to notify health care providers and parents of the Meningococcal requirement.

Upon entering the sixth and the **TWELFTH** grade of any public, private, or parochial school, students are to have received an immunization containing MENINGOCOCCAL CONJUGATE VACCINE (MCV4) in accordance with the recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. The immunization requirement consists of:

The 1st dose received on or after the 11th birthday, and the 2nd dose received, on or after the 16th birthday, at least eight weeks after the 1st dose. *If the 1st dose is received at 16 years of age or older, only 1 dose is required.*

More information about the Meningococcal Vaccine Requirements can be found at:
http://www.cdc.gov/vaccines

Documentation from the provider indicating that the MCV4 vaccine was administered, *including both the providers signature and date of administration* need to be submitted to the school HEALTH OFFICE prior to the start of the school year. Please see your Health Care Provider at the earliest opportunity.

You may mail your student's health information to: Joliet Catholic Academy 1200 N. Larkin Avenue, Joliet, IL 60435, ATTN HEALTH OFFICE or FAX directly to the nurses' office @ 815-741-3015.

Please feel free to contact the Health Office with any questions or concerns regarding your student's health and wellbeing. Thank you for your prompt attention in this matter.

Mrs. Jill Batusich RN JBatusich@jca-online.org
Mrs. Barb Huey RN BHuey@jca-online.org
JCA Health Nurse
815-741-0500 EXT. 275

VACCINE INFORMATION STATEMENT

Meningococcal Vaccines

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

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

1 What is meningococcal disease?

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

Meningococcal disease also causes blood infections.

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

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

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

2 Meningococcal vaccine

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

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

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

3 Who should get meningococcal vaccine and when?

Routine vaccination

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

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

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

Other people at increased risk

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

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

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

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

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

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

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

5 What are the risks from meningococcal vaccines?

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

> Brief fainting spells and related symptoms (such as jerking or seizure-like movements) can follow a vaccination. They happen most often with adolescents, and they can result in falls and injuries.
>
> Sitting or lying down for about 15 minutes after getting the shot—especially if you feel faint—can help prevent these injuries.

Mild problems

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

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

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

Severe problems

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

6 What if there is a serious reaction?

What should I look for?

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

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

What should I do?

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

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

7 The National Vaccine Injury Compensation Program

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

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

8 How can I learn more?

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

Vaccine Information Statement (Interim)

Meningococcal Vaccine

10/14/2011

42 U.S.C. § 300aa-26

Office Use Only

2015-2016 Informed Consent to Receive Vaccines

List your name exactly as it appears on your Medicare or other insurance card. Provide the date of birth and street address that your insurance has on file for you. Providing incorrect information may cause your insurance to reject payment.

PATIENT INFORMATION

First Name: ____________________ **Last Name:**____________________**Date of Birth:** ____________

Street Address: ____**Age:**____________

City: ____ **State:** ____________ **Zip:** ____________

Phone: (_____)______________________ **Male / Female (circle one)**

Drug Allergies: ____

When did you last receive the following vaccines?

Hepatitis B	Date ____/____/____	____Never/Unsure	Tetanus	Date ____/____/____	____Never/Unsure
Influenza (flu)	Date ____/____/____	____Never/Unsure	Whooping cough	Date____/____/____	____Never/Unsure
Pneumonia	Date ____/____/____	____Never/Unsure	Other ________	Date____/____/____	____Never/Unsure
Shingles	Date ____/____/____	____Never/Unsure			

PHYSICIAN INFORMATION

Physician: ____**Physician Phone: (_____)**__________

Physician Address: ____

INSURANCE INFORMATION

Important Notice: Immunizations may or may not be covered by your insurance. We will verify eligibility under your plan and attempt to collect payment from your insurance for all immunizations. If we are unable to confirm eligibility, **you may still opt to receive it at our pharmacy and pay for it yourself** or your insurance may cover administration of the vaccine by your physician. **You are responsible for payment for products or services you receive that are not paid for by your plan.** Please provide your insurance information below.

Note for patients with Medicare: To receive the flu vaccine at no charge at the pharmacy, you must have traditional **Medicare Part B, Railroad Medicare**, or **select Medicare HMO plans**. If you have a **Medicare HMO plan,** it must be a plan that has contracted with the pharmacy to provide immunizations.

Insurance name (i.e. Medicare B, Aetna, etc.): ______________________________________

ID # (include any letters):____________________________ Group #: ______________________

PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE

I have read, or have had read to me, the provided Vaccine Information Statement(s) ("VIS"). I have had the opportunity to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I understand that my receipt of this vaccination[1] is subject to reporting, by my pharmacy or its business associate, to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Dept. of Health, if applicable, and I authorize these disclosures. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); New Albertson's Inc., Albertson's LLC and their subsidiaries and affiliates; the respective directors, officers, employees, and agents of New Albertson's Inc., Albertson's LLC and their subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability and claims that might arise from this vaccination.

Please initial that you received our HIPAA Notice of Privacy Practices

__________ (initials)

______________________________ ______________________

Patient/Parent/Guardian Signature **Date**

[1] Including any vaccination that may be used for treatment of the HIV virus, a related condition, or any other vaccination granted additional privacy protections under state or federal law.

Please answer yes or no to the questions below. If any questions are unclear, please ask for help.

	YES	NO
1. Do you have fever, diarrhea or vomiting today?		
2. Are you allergic to eggs, Baker's yeast, preservatives (e.g. sulfites), thimerosal, streptomycin, neomycin, Arginine, gelatin or latex?		
3. Have you ever had a serious reaction to any vaccine which required medical care?		
4. Are you or anyone on your home, or anyone you take care of being treated with chemotherapy, radiation for cancer, have HIV/AIDS or any immune deficiency disorder?		
5. Do you have a long term health problem such as heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes) or anemia or other blood disorder?		
6. Have you had Immune (gamma) Globulin or a transfusion of blood or plasma in the past year?		
7. Have you had Guillain-Barre Syndrome, a condition which may cause paralysis?		
8. Are you taking in blood thinning medications (i.e. aspirin, warfarin etc.)?		
9. Are you on immunosuppressive therapy, including high-dose corticosteroids?		
10. Have you received any vaccines in the past 4 weeks?		
11. **For women**: Are you pregnant or planning pregnancy in the next month?		

Patient name:

Patient DOB:

NOTE: The pharmacist will review these questions with you before giving the immunization. Based on your answers, they may refer you to speak with your physician to make sure the vaccine is right for you.

VACCINE INFORMATION (Office use only)

Vaccine | **Lot #** | **Exp. Date** | **Manufacturer** | **Dose (ml)**

Route | **Right or Left Arm** **Admin. Site** | **Admin / VIS given date** | **VIS publication date**

ADMINISTRATOR* | **STORE # (Where pt received vaccine)**

Vaccine | **Lot #** | **Exp. Date** | **Manufacturer** | **Dose (ml)**

Route | **Right or Left Arm** **Admin. Site** | **Admin / VIS given date** | **VIS publication date**

ADMINISTRATOR* | **STORE # (Where pt received vaccine)**

*By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving vaccine.

Dear Parent:

Please fill out the form below to expedite the billing of your child's meningitis vaccine. By providing this information ahead of time, we will be able to administer the vaccine and charge you the copay (if any) without delay. You may fax this information to our pharmacy ahead of time so we can process the claim and call you with the price. If you choose not to do this, we can still take care of your child the day of the clinic but it just may take a few extra minutes of you and your child's time. Thank you!

Insurance plan:

Medical insurance carrier: ________________________________

ID number on card: ______________________________________

Group number on card: ___________________________________

Prescription insurance carrier: _____________________________

BIN number on card: _____________________________________

PCN number on card: _____________________________________

ID number on card: ______________________________________

Group number on card: ___________________________________

Child's name: ________________________________DOB: _________________

Best number to reach you with price and/or questions: ____________________

Sincerely,
Osco Drug Pharmacy
1403 W Jefferson St, Joliet
Phone: 815-725-1290
Fax: 815-725-7926