3700 W. Sovereign Path
Lecanto, FL 34461-8071
352-527-0068

1007 W. Main Street
Inverness, FL 34450-4625
352-726-1931

January / February 2024

Attention Parents/Guardians of 6th/7th graders,

Florida Statute (1003.22) requires that all students entering 7th grade receive a Tdap vaccine (tetanus, diphtheria, pertussis booster). The Citrus County School Board, in conjunction with the Florida Department of Health Citrus County, is providing families the opportunity for their 6th grade students in need of the Tdap vaccination to be immunized at school at NO COST OR COPAY TO THEIR FAMILIES! The health department is required to collect health insurance information if your child has coverage. If you have coverage for your child, the health department will bill your insurance directly. If your child is not covered by a health insurance plan, he/she will receive the vaccine at no cost. Your child's health insurance status will stay confidential.

We encourage you to take advantage of this program by:

- Reading the Tdap Vaccine Information Statement
- Filling out the Tdap consent form attached and returning it to your child's school.

School	Date of Vaccine Clinic	Deadline to return Signed Packet to School
Inverness Middle School	January 19th, 2024	**January 12th, 2024**
Citrus Springs Middle School	February 2nd, 2024	**January 26th, 2024**
Crystal River Middle School	February 9th, 2024	**February 2nd, 2024**
Lecanto Middle School	February 16th, 2024	**February 9th, 2024**

If your child has already received the Tdap vaccine, they will not need another one. Please bring their updated immunization information to your child's school so we can update his/her records.

In addition, the Florida Department of Health, Citrus County is offering two additional vaccines recommended for pre-teens during the school-based vaccination clinics:

- the first of a two dose HPV vaccination series and
- the first of a two dose MCV4 (Meningitis) vaccination series

If you are interested in your child receiving the HPV vaccine (recommended -not required) or the MCV4 vaccine (recommended -not required), please read the Vaccine Information Statements, complete, sign and return the separate HPV and/or MCV4 consent forms, along with the required waiver form to your student's school.

Please contact the Florida Department of Health Citrus County at (352) 513-6025 if you have any questions regarding vaccinations.

Sincerely,

Michelle Shank
Supervisor, School Health Citrus County Schools (352) 527-0090

Janora Wade
Community Health Nursing Director
Florida Department of Health in Citrus County
(352) 513-6016

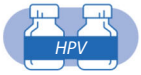
Vaccines for Preteens and Teens: What Parents Should Know

All boys and girls need three vaccines at ages 11-12 to protect against serious diseases. Preteens and teens should also get a yearly flu vaccine, as well as any vaccines they missed when they were younger.

What vaccines does my child need?

Dose 1: *Ages 11-12*
Dose 2: *Age 16*

Meningococcal vaccines protect against a type of bacteria that can cause serious illnesses. The two most common types of illnesses include infections of the lining of the brain and spinal cord (meningitis) and bloodstream. All preteens should get the meningococcal conjugate vaccine (MenACWY). Teens may also receive a serogroup B meningococcal vaccine (MenB), preferably at 16 through 18 years old.



Dose 1: *Ages 11-12*
Dose 2: *6-12 months later*

HPV vaccine protects both girls and boys from future infections that can lead to certain types of cancer. Children who get their first dose on or after their 15th birthday will need three doses.

Dose 1: *Ages 11-12*

Tdap vaccine protects against three serious diseases: tetanus, diphtheria, and pertussis (whooping cough).

Yearly Dose:
Ages 6 months and older

Flu vaccine helps protect against seasonal flu. Even healthy preteens and teens can get very sick from flu and spread it to others. The best time to get an annual flu vaccine is before flu begins causing illness in your community, ideally before the end of October. Flu vaccination is beneficial as long as flu viruses are circulating, even in January or later.

When should my child be vaccinated?

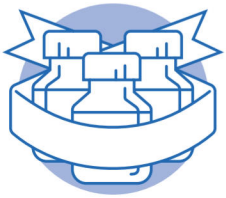
A good time to get these vaccines is during a yearly wellness check. Your child can also get these vaccines at a physical exam required for school, sports, or camp. **If your child missed any doses of recommended vaccines, ask your doctor or nurse about getting them now.**

Are these vaccines safe?

These vaccines have been studied very carefully and are very safe. They can cause mild side effects, like soreness or redness in the part of the arm where the shot is given. Some preteens or teens might faint after getting a shot. Sitting or lying down when getting a shot, and then for about 15 minutes after the shot, can help prevent fainting. Serious side effects are rare. It is very important to tell the doctor or nurse if your child has any serious allergies, including allergies to yeast, latex, or chicken eggs, before they receive any vaccines.

Can I get help paying for these vaccines?

Most health insurance plans cover routine vaccinations. The Vaccines for Children (VFC) program also provides vaccines for children 18 years and younger who are uninsured, underinsured, Medicaid-eligible, American Indian, or Alaska Native. Learn more at www.cdc.gov/Features/VFCprogram.



Talk to your child's doctor or nurse about the vaccines your child needs or visit **www.cdc.gov/vaccines/parents**

Last updated JULY 2019

Screening Checklist for Contraindications to HPV, MenACWY, and Tdap Vaccines for Pre-Teens

YOUR CHILD'S NAME _____

CHILD'S DATE OF BIRTH _____ / _____ / _____
month day year

For parents/guardians: The following questions will help us determine if human papillomavirus (HPV), meningococcal conjugate (MenACWY), and tetanus, diphtheria, and acellular pertussis (Tdap) vaccines may be given to your pre-teen. If you answer "yes" to any question, it does not necessarily mean your teen should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please call 352-513-6025

Please note a seperate consent is required for each vaccine.	yes	no	don't know
1. Is your child sick today?	☐	☐	☐
2. Does your child have allergies to a vaccine component or to latex?	☐	☐	☐
3. Has your child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has your child had a brain or other nervous system problem?	☐	☐	☐
5. For females: Is your child pregnant?	☐	☐	☐
6. Has your child ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
7. Is your child anxious about getting a shot?	☐	☐	☐

Demographic Information: (Circle One) White American Indian/Native Alaskan Black Asian Hispanic Other

☐ **INSURANCE** ☐ **MEDICAID (Prestige, United Health Care, Stay Well/Well Care or Sunshine)**

☐ **MY CHILD DOES NOT HAVE INSURANCE**

We may bill your insurance company for vaccines. You will not be billed, and there will be no co-pay or deductible due. This service is offered NO COST to you! As always, answers are confidential. Please fill out the following questions regarding your child's health insurance plan:

Insurance Company: _____ **Member ID:** _____

Policy Holder's Name: _____ **Policy Holder's Date of Birth** _____

Parent/ Guardian completing form Print: _____ **Date:** _____
Parent/Guardian Phone #: _____
Health Department Staff reviewing form: _____ **Date:** _____

Adapted from:

Immunize.org

FOR PROFESSIONALS www.immunize.org / **FOR THE PUBLIC** www.vaccineinformation.org

REQUIRED*
Tdap

2023-2024 Tdap Vaccine Consent Form
THIS FORM MUST BE RETURNED

*Section 1003.22, *Florida Statutes*, and Rule 64D-3.046, *Florida Administrative Code*
PLEASE COMPLETE THE INFORMATION BELOW (Unreadable and incomplete forms may not be accepted.)

Full, Legal Name of Student (*First Name Middle Initial. Last Name)* PLEASE PRINT	**Student Number**	**Name of School**	
Parent/Guardian Name (*First Name Middle Initial. Last Name)*	**Relationship to Student**	**Homeroom Teacher**	**Grade**
Street Address	**Email Address**	**Birth Date** (month/date/year)	**Age** **Sex**
City:	**Zip Code**	**Home Phone #**	**Cell Phone #**

☐ **No, I Do not want my Child to receive the Tdap vaccine. If you decline to have your child receive the Tdap Vaccine**
STOP DO NOT COMPLETE THE BOTTOM PORTION OF THIS FORM

I have received, read, and understand the CDC Vaccine Information Statement for the Tdap vaccine and the Notice of Privacy Practices. I have read these documents and understand the risk and benefits of the Tdap vaccine. I give permission to the Florida, Department of Health Citrus County to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing, and storage per Florida Department of Health policies, to assure optimal healthcare for my child.

☐ **YES, I Want to Help Protect My Child, Family, and Community from Vaccine Preventable Diseases by Allowing My Child to Receive the Tdap Vaccine that is required for 7th grade entry!**

_____ _____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

Tdap Intramuscular (IM), 0.5mL

VIS: 08/06/2021

Vaccine Lot # &
Expiration Date Label

Date Given: _____ Arm: ☐ Right ☐ Left

Signature/Title _____

HPV
Recommended*

2023-2024 HPV Vaccine Consent Form
THIS FORM MUST BE RETURNED

*CDC recommends that 11- to 12-year-olds receive two doses of HPV vaccine six months apart.
To protect against cancers caused by human papillomavirus (HPV) infections.
* PLEASE COMPLETE THE INFORMATION BELOW (Unreadable and incomplete forms may not be accepted.)

Full, Legal Name of Student (*First Name Middle Initial. Last Name)* PLEASE PRINT	**Student Number**	**Name of School**	
Parent/Guardian Name (*First Name Middle Initial. Last Name)*	**Relationship to Student**	**Homeroom Teacher**	**Grade**
Street Address	**Email Address**	**Birth Date** (month/date/year)	**Age** **Sex**
City:	**Zip Code**	**Home Phone #**	**Cell Phone #**

I have received, read, and understand the CDC Vaccine Information Statement for the HPV vaccine and the Notice of Privacy Practices. I have read these documents and understand the risk and benefits of the HPV vaccine. I give permission to the Florida, Department of Health Citrus County to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing, and storage per Florida Department of Health policies, to assure optimal healthcare for my child.

☐ **No, I Do not want my Child to receive the HPV vaccine. If you decline to have your child receive the HPV Vaccine STOP DO NOT COMPLETE THE BOTTOM PORTION OF THIS FORM**

☐ **YES, I Want to Help Protect My Child against cancers caused by human papillomavirus (HPV) infections by Allowing My Child to Receive the HPV Vaccine as is recommended by the CDC! I understand that the HPV vaccine is a series of two doses and that I will be notified when the next dose is due and where/how to obtain this dose.**

_____ _____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

HPV Intramuscular (IM), 0.5mL
VIS: 08/06/2021
Date Given: _____ Arm: ☐ Right ☐ Left

Vaccine Lot # &
Expiration Date Label

Signature/Title _____

NOTICE: The HPV Vaccination is not required by State/Federal Law and therefore is not required by the Citrus County School Board for attendance at school. The Citrus County School Board is not liable for any injuries to your student/child if you voluntarily choose to have the HPV Vaccination administered. No student/child shall have the HPV Vaccination administered at any Citrus County School Board facility without the execution of a Waiver and Release by the student/child's parent or legal guardian.

MCV4
Recommended*

2023-2024 MCV4 Vaccine Consent Form
THIS FORM MUST BE RETURNED

* CDC recommends that 11-18 year old's receive two doses of MCV4. 1st at 11-12 y/o and 2nd 16 y/o

* PLEASE COMPLETE THE INFORMATION BELOW (Unreadable and incomplete forms may not be accepted.)

Full, Legal Name of Student (*First Name Middle Initial. Last Name*) PLEASE PRINT	**Student Number**	**Name of School**	
Parent/Guardian Name (*First Name Middle Initial. Last Name*)	**Relationship to Student**	**Homeroom Teacher**	**Grade**
Street Address	**Email Address**	**Birth Date** (month/date/year)	**Age** **Sex**
City:	**Zip Code**	**Home Phone #**	**Cell Phone #**

I have received, read, and understand the CDC Vaccine Information Statement for the MCV4 vaccine and the Notice of Privacy Practices. I have read these documents and understand the risk and benefits of the MCV4 vaccine. I give permission to the Florida, Department of Health Citrus County to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing, and storage per Florida Department of Health policies, to assure optimal healthcare for my child.

☐ **No, I Do not want my Child to receive the MCV4 vaccine. If you decline to have your child receive the MCV4 Vaccine STOP DO NOT COMPLETE THE BOTTOM PORTION OF THIS FORM**

☐ **YES, I Want to Help Protect My Child for strains from vaccine preventable meningococcal disease (A.Y.C.W.)by Allowing My Child to Receive the HPV Vaccine as is recommended by the CDC! I understand that the MCV4 vaccine is a series of two doses and that I will be notified when the next dose is due and where/how to obtain this dose.**

_____ _____ _____

Printed Name of Parent/Guardian | Signature of Parent/Guardian | Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

HPV Intramuscular (IM), 0.5mL
VIS: 08/06/2021
Date Given: _____ Arm: ☐ Right ☐ Left

Vaccine Lot # &
Expiration Date Label

Signature/Title _____

NOTICE: The MCV4 Vaccination is not required by State/Federal Law and therefore is not required by the Citrus County School Board for attendance at school. The Citrus County School Board is not liable for any injuries to your student/child if you voluntarily choose to have the MCV4 Vaccination administered. No student/child shall have the MCV4 Vaccination administered at any Citrus County School Board facility without the execution of a Waiver and Release by the student/child's parent or legal guardian.

APPLICANTS UNDER AGE 18 MUST HAVE PARENT OR GUARDIAN COMPLETE PARTS "A" AND "B".

PART "A" - WAIVER & RELEASE FROM LIABILITY

hereby give permission for my child
to participate in the "Event" listed below. In consideration of being permitted to participate, compete, officiate, observe, work for, or for any purpose participate in any way in the **HPV AND/OR MENINGOCOCCAL VACCINATION OF MY CHILD** ("Event") each of the undersigned, for himself/herself, his/her personal representatives, heirs, next of kin, acknowledges, agrees and represents that he/she:

1. HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE the Citrus County School Board, its members, officers, employees, owners and lessees of the premises used to conduct the event and each of them, their officers and employees, all for the purposes herein referred to as "releasees", from all liability to the undersigned, his/her personal representatives, assigns, heirs, and next of kin for any and all damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned, whether caused by the negligence of the releasees or otherwise while the undersigned is, and/or competing, officiating in, observing, or working for or for any purpose participating in the Event;

2. • HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releasees and each of them from any loss, liability, damage, or cost they may incur due to the presence of the undersigned in any way competing, officiating, observing or working for, or for any purpose participating in the Event and whether caused by negligence of the releasees or otherwise.

3. HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE due to the negligence of releasees or otherwise and/or while competing, officiating, observing, or working for or for any purpose participating in the Event.

4. HEREBY expressly acknowledges and agrees that the Event is dangerous and involves the risk of serious injury and/or death and/or property damage. Each of the undersigned further expressly agrees that the foregoing release, waiver, and indemnity agreement is intended to be as broad and inclusive as is permitted by the law of the Province or State in which the event is conducted and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue to full legal force and effect.

THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT and further agrees that no oral representations, statements or inducement apart from the foregoing written agreement have been made.

1212/14//14/16 16

This waiver, release, and indemnification agreement specifically embraces each and every event sanctioned, authorized or promoted by said releasees applies to each and *every* event or activity hereinabove mentioned, and has the same effect as if executed after each and every activity or event in which the undersigned participates so that the parties herein intended to be released and indemnified shall be fully and effectively released and indemnified as to each and every event hereinabove described.

Signed: **Witness:**

Date:

PART "B" - PARENT/GUARDIAN WAIVER - RELEASE FROM LIABILITY

(If applicant is under 18 years of age, the parent(s) or guardian(s) must execute in addition to the above, the following waiver.)

The undersigned (name of parent(s)) referred to as the parent(s) and natural guardian(s) or legal guardian(s) of (name of child) does hereby represent that he/she (they) is (are), in fact, acting in such capacity and agrees to save and hold harmless and indemnify each and all of the parties herein referred to above releasees from all liability, loss, cost, claim or damage whatsoever may be imposed upon said releasees because of any defect in or lack of such capacity to so act and release said releasees on behalf of both of the undersigned.

Signed:

Relationship to Minor:

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

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

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

1. Why get vaccinated?

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

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

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

2. Tdap vaccine

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

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

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

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

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

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

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

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

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

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

Your health care provider can give you more information.

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

4. Risks of a vaccine reaction

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

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

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

5. What if there is a serious problem?

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

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

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

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.

VACCINE INFORMATION STATEMENT

Meningococcal ACWY Vaccine:
What You Need to Know

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

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

1. Why get vaccinated?

Meningococcal ACWY vaccine can help protect against **meningococcal disease** caused by serogroups A, C, W, and Y. A different meningococcal vaccine is available that can help protect against serogroup B.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

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

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

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

2. Meningococcal ACWY vaccine

Adolescents need 2 doses of a meningococcal ACWY vaccine:

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

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

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

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

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

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

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

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

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

Your health care provider can give you more information.

4. Risks of a vaccine reaction

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

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

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

5. What if there is a serious problem?

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

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

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

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

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

HPV (Human Papillomavirus) Vaccine: *What You Need to Know*

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

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

1. Why get vaccinated?

HPV (human papillomavirus) vaccine can prevent infection with some types of human papillomavirus.

HPV infections can cause certain types of cancers, including:

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

HPV infections can also cause anogenital warts.

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

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

2. HPV vaccine

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

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

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

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

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

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

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

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

Your health care provider can give you more information.

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

4. Risks of a vaccine reaction

- Soreness, redness, or swelling where the shot is given can happen after HPV vaccination.
- Fever or headache can happen after HPV vaccination.

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

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

5. What if there is a serious problem?

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

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

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

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.