Dear Parents,

We have a rare opportunity to provide free Tdap and Meningococcal vaccinations for children and teens age 11 and older in schools that contract for health services with the Department of Health. This one-time project allowing us to provide vaccinations at no cost may not be available again in the future.

All preteens and teens need a one-time dose of Tdap, a vaccine that protects them from tetanus, diphtheria, and whooping cough (pertussis). If your child has already had a dose of Tdap, he/she does not need to be vaccinated with Tdap at this time, but will need a tetanus-diphtheria (Td) shot every ten years from the date of their dose of Tdap.

All preteens and teens need 2 doses of Meningococcal Vaccine (MenACWY). Usually the first dose is given at age 11-12, and the second one at age 16. If your child missed the opportunity to get their first dose at age 11-12, it is not too late for them to start the series. Meningococcal B vaccine is also recommended by some providers, but is not available through this project.

You are encouraged to check your adolescent's vaccination record, or contact us to do so.

We will be providing the free vaccination clinic at MILLER HIGH SCHOOL.

From ----**9:00AM TO 12:00PM** on **MONDAY, MARCH 20TH, 2017.**

The information about tetanus, Diphtheria, pertussis, and meningococcal diseases and the vaccines that protect against them is included for your review. Also included are consent forms that allow us to vaccinate. You are welcome to attend the clinic with your child, or can complete the consent forms and return them to the school by **WEDNESDAY, MARCH 15TH, 2017.**

If you have questions about the clinic, or about your child's vaccination record, please feel free to contact us at: HAND COUNTY COMMUNITY HEALTH. Thank you.

HAND COUNTY COMMUNITY HEALTH

318 W. 5TH ST, MILLER SD 57362

605-853-2147

POD Exercise: MENINGOCOCCAL VACCINE CONSENT FORM

Information about person to be vaccinated ***(Please print)***

Last Name: ____________________

First Name: ____________________ Age: ______

Date of Birth: ______________ Sex: _____ M _____ F

Address: ____________________

City: ____________________ Zip: ________

Parent/Guardian: ____________________

Phone number: ____________________

(For office use only)

Clinic/POD:

If history of previous dose, check SDIIS

Two doses are recommended for adolescents 11-18 yrs.

1st dose at age 11-12, with a booster dose at age 16

★ State Law requires I dose for Middle School entry

★ If the 1st dose is given between age 13-15, a booster dose should be given between 16-18

★ If 1st dose is given after 16th birthday, booster not needed

★ A dose on or after age 10 is considered valid

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information. Immunization records remain confidential, and any person who fails to protect the confidentiality of this information is guilty of a Class 1 misdemeanor. If you choose NOT to have your/your child's immunization record shared with other providers you may request a refusal form.

For a child being vaccinated - check any that apply

_____ Enrolled in Medicaid

_____ No health insurance

_____ Has health insurance

_____ American Indian or Alaskan Native

_____ Health Insurance DOES NOT pay for vaccines

Please answer the following questions for the person to be vaccinated:

Question	Yes	No	Don't Know
1) Is the child sick today?	____	____	____
2) Does the child have allergies to medication, food, a vaccine component, or latex?	____	____	____
3) Has the child ever had a serious reaction to a vaccine in the past?	____	____	____
4) Has the child received a previous dose of meningococcal vaccine?	____ *	____	____

* If previous dose given, please enter date if known: ____________________

Consent for Vaccination

I have been provided a copy of and have read or have had explained to me the information about meningococcal vaccine and have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Signature ____________________ Date ____________

(Parent or guardian if minor)

for office use only

	Type	Date/Time	Vaccine Manufacturer	Vaccine Lot number	Route	Site (Circle)	Date of VIS Publication	Full signature of person administering vaccine
Meningococcal	MenACWY	03/20/2017	Sanofi Pasteur (Menactra)	U5410AA	IM*	L R Deltoid	3/31/16	

The Department of Health Notice of Privacy Practices can be found on the following website: http://doh.sd.gov/documents/HIPAANotice.pdf

* IM - Intramuscularly

version 7.13.16

POD Exercise: Tdap VACCINE CONSENT FORM

Information about person to be vaccinated **(Please print)**

Last Name: ______________________________

First Name: ______________________ Age: _______

Date of Birth: ________________ Sex: _____ M _____ F

Address: ______________________________

City: ______________________ Zip: __________

Parent/Guardian: ______________________________

Phone number: __________________

(For office use only)

Clinic/POD:

★ State Law requires1 dose for Middle School entry

★ Children who have received a prior dose of Tdap at age 7 or after do not need to be re-vaccinated

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For a child being vaccinated - check any that apply

_____ Enrolled in Medicaid
_____ Health Insurance
_____ Health insurance DOES NOT pay for vaccines
_____ No health Insurance
_____ American Indian or Alaskan Native

Please answer the following questions for the person to be vaccinated:

	YES	NO	Don't Know
1) Is the child sick today?	_____	_____	_____
2) Does the child have allergies to medications, food, a vaccine component, or latex?	_____	_____	_____
3) Has the child ever had a serious reaction to a vaccine in the past?	_____	_____	_____
4) Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	_____	_____	_____

CONSENT for Vaccination

I have been provided a copy of and have had explained to me the information about the Tetanus, Diphtheria, Pertussis diseases and the Tdap vaccine. I have had the chance to ask questions that were answered to my satisfaction.
I believe I understand the benefits and the risks of the vaccine and ask that the vaccine be given to the child above for whom I am authorized to make this request.

Signature ______________________________ **Date** ______________

(Parent or guardian)

or office use only

Date/Time	Vaccine Manufacturer	Vaccine Lot number	Route	Site (Circle)	Date of VIS Publication	Full signature of person administering vaccine
03/20/2017	GlaxoSmithKline	9NA32	IM *	Left Deltoid Right Deltoid	2/24/15	

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* IM-intramuscularly

version 7/13/16