March 28,2023

TO: Parents of Rising 12th Grade Students

FROM: Northumberland Public Schools and Northumberland Health Department

SUBJECT: Meningococcal Vaccination for 12th Graders

State law requires all students entering 12th grade receive a booster dose of Meningococcal ACWY vaccine. This means all rising 12th graders must have received a dose of Meningococcal ACWY vaccine before they can start 12th grade. If you child has had a Meningococcal ACWY vaccine on or after the age of 16, they are only required to have one dose.

If your child has already received their vaccination, please send a copy of the vaccination record to the school. If your child has not received this vaccination, and you would like him/her/them to be vaccinated at school, the Health Department will provide the required immunization at Northumberland High School on **Monday April 24, 2023 starting at 09:30am** at no cost to the student / family.

If your child has private insurance/FAMIS/Medicaid, enter the coverage information on the consent form as requested along with a copy of the front and back of your insurance card. VDH is required to bill for the service if you have medical coverage. Vaccine is limited and will be provided on a first come, first served basis.

Attached are two forms:

1- 2023 Student Vaccination Consent Form (complete front and back and return to the school),

2- Meningococcal ACWY Vaccine Information Statement (read and keep)

If you child is sick, he/she/they will not be able receive the vaccine. Ensure your child is wearing clothing that allows their arm to be easily accessible. In order for your child to be vaccinated at school, the Vaccination Consent Forms must be filled out and returned to the school as soon as possible, but no later than **April 21, 2023.** Ensure your child is wearing clothing that allows their arm to be easily accessible.

If you have any questions, please contact the school nurse.

FECHA: Marzo 28, 2023

PARA: Padres de estudiantes de 12° grado

DE: Escuelas Públicas del Condado de Northumberland Departamento de Salud del Condado de Northumberland.

TEMA: Vacunación meningocócica para estudiantes de 12° grado

La ley estatal requiere que todos los estudiantes que ingresan al 12° grado reciban una dosis de refuerzo de la vacuna meningocócica ACWY. Esto significa que todos los estudiantes de 12° grado en ascenso deben haber recibido una dosis de vacuna meningocócica ACWY antes de que puedan comenzar el 12° grado. Si su hijo no ha recibido previamente una dosis de vacuna meningocócica ACWY, necesitará un total de dos dosis. Si su hijo ha recibido una vacuna meningocócica ACWY en o después de los 16 años, solo se requiere que tenga una dosis.

Si su hijo(a) ya ha recibido esta vacuna, por favor envíe una copia del registro de vacunación a la escuela. Si su hijo no ha recibido esta vacuna, y usted desea que él / ella / ella se vacune en la escuela, el Departamento de Salud proporcionará la inmunización requerida el **Northumberland High School at 09:30am de abril 24, 2023.**

Si su hijo tiene seguro privado/FAMIS/Medicaid, ponga la informacion de cobertura en el formulario de consentimiento requerido junto con una copia del frente y la parte posterior de la tarjeta del seguro medico.(VDH) Departamento de Salud de Virginia, tiene la obligacion de facturar por los servicios a su seguro medico. La vacuna es limitada y se proporcionará por orden de llegada.

Adjuntos son dos formularios:

1- Formulario de Consentimiento de Vacunación Estudiantil 2023 (frente y espalda completos y regreso a la escuela),

2- Declaración de información sobre la vacuna meningocócica (leer y conservar).

Para que su hijo sea vacunado en la escuela, los Formularios de Consentimiento de Vacunación deben ser llenados y devueltos a la escuela tan pronto como sea posible, pero no más tarde de **de abril 21, 2023.** Asegúrese de que su hijo lleve ropa que permita que su brazo sea fácilmente accesible.

Si usted tiene alguna pregunta, por favor póngase en contacto con la escuela.

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?

- 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.

2023 ADOLESCENT VACCINATION CONSENT FORM

(Tdap, HPV, Meningococcal ACWY)

VDH VIRGINIA DEPARTMENT OF HEALTH

Name: _____
Last First Middle

Date of Birth: ___/___/___ Age: _____ Gender: ☐ M ☐ F

Health Department Use Only
Cl ID#
Encounter #:

If minor - parent/guardian's name: _____
Last First M.I.

Parent/Guardian's Date of Birth: ___/___/___ Parent's SSN: _____ *Optional*

Address: _____ City: _____ ZIP: _____

Grade: _____ Home Room Teacher: _____ School: _____

IMPORTANT Parent/Guardian Phone # Home: _____ Cell: _____ Work: _____

Emergency Contact: _____ Emergency contact number: _____
(If other than Head of Household)

My child will be 11 years of age or older on the day of the scheduled vaccination clinic: YES ☐ NO ☐

Please check YES or NO to all the questions below to determine if your child can receive offered vaccines at school. The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO
Has your child ever had a serious allergic reaction to any vaccine component or yeast?	☐	☐
Has your child ever had a serious reaction to a previous dose of Tdap, HPV, or Meningococcal vaccine in the past?	☐	☐
Did your child experience a coma, decreased level of consciousness, or long or multiple seizures within seven days following a dose of DTP, DTaP or Tdap?	☐	☐
Does your child have epilepsy or another nervous system problem; ever had severe swelling or severe pain after a previous dose of DTP, DTaP, DT, or Td; or ever had Guillain-Barré Syndrome (GBS)? If so, consult your doctor about receiving Tdap vaccine. (A note may be required to proceed in school setting)	☐	☐
Is your child pregnant? If yes, your child will not receive the HPV vaccine, but may receive the other vaccines.	☐	☐

If you answered YES to questions, this vaccine(s) may not be safe for your child and s/he WILL NOT receive these vaccines at school. If your child has a severe life-threatening allergy, please speak with your child's doctor before consenting to vaccination.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:
1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. 2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

*** Insurance*:** Please answer the following: This information is required for federal funding purposes for VFC vaccines.

***Note:** Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program. If your child is covered by a private health insurance plan, the Department shall seek reimbursement for all allowable costs associated with the provision of the vaccine. **Your child will not be vaccinated if you do not provide all requested insurance information below.**

My child:( ) is *not* insured (not covered by private insurance, Medicaid, Medicaid MCO or FAMIS)
( ) is American Indian or is an Alaska Native
( ) has Medicaid MCO with: Virginia Premier, Optima Community Care, Anthem Healthkeepers Plus, Molina Healthcare, United Healthcare Community Plan, or Aetna Better Health (circle your plan)
Member ID # as shown on your card: _____ is this a FAMIS plan? ☐Y ☐N
( ) has Medicaid or FAMIS (circle one) that is not a MCO plan: Medicaid # _____
( ) has other insurance not listed above (specify plan name) _____
Policy ID # _____ Policy holder's name _____
Attach a copy of the front & back of insurance card or provide the following information:
Insurance company address _____
Insurance company phone number _____

I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third-party payer to pay any authorized benefits to VDH on my behalf.

Office of Privacy and Security

Authorization for Disclosure of Protected Health Information

This consent gives the Virginia Department of Health (VDH) permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that immunization records of my child will be retained for 21 years after birth.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

☐ Please check box if you wish to receive a copy of the Virginia Department of Health Notice of Privacy Practices.

CONSENT FOR CHILD'S HPV VACCINATION:

☐ My child has NEVER been vaccinated for HPV. **Note: Your child will require two doses: the first dose now and the 2nd Dose 6 months after Dose 1. NOTE: children with certain medical conditions may require three doses. Please consult your provider to assess the need for a third dose.**

☐ My child has received the first dose of the HPV vaccine. **Note: the 2nd Dose should be received 6 months after Dose 1.**

I have read the 2021 Vaccination Information Statement (VIS) for the HPV Vaccine. I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the HPV vaccine (shot) **If needed, I give my consent for my child to receive the second dose approximately six months after the first dose.**

Signature of Parent or Legal Guardian: X _____ **Date:** ___/___/___

CONSENT FOR CHILD'S MenACWY VACCINATION:

I have read the 2021 Vaccination Information Statement (VIS) for the MenACWY Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Meningococcal ACWY vaccine (shot).

Signature of Parent or Legal Guardian: X _____ **Date:** ___/___/___

CONSENT FOR CHILD'S Tdap VACCINATION:

I have read the 2021 Vaccination Information Statement (VIS) for the Tdap Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Tdap vaccine (shot).

Signature of Parent or Legal Guardian: X _____ **Date:** ___/___/___

Please send a copy of my child's immunization record to her/his doctor at the following address.

*Doctor's Name*_____ *Mailing Address*_____ *City*_____ *State*_____ *ZIP*_____

HEALTH DEPARTMENT USE ONLY

Date	Item code	Fund Source	Lot Number	Vaccine Administration Site	Provider #
	Tdap	VFC STF		RA LA	
	MenACWY	VFC STF		RA LA	
	HPV #1	VFC STF		RA LA	
	HPV #2	VFC STF		RA LA	
		VFC STF		RA LA	
Comments					
Provider Name/Signature and Date					

FORMULARIO DE CONSENTIMIENTO DE VACUNACIÓN PARA ADOLESCENTES DE 2023

VDH Virginia Department of Health

(Tdap, VPH, ACWY meningocócica)

Health Department Use Only
CLIDN#:
Encounter#:

Nombre: _____
Apellido Nombre Segundo nombre

Fecha de nacimiento: ___/___/___ Edad: ____ Sexo: ☐ M ☐ F

Si es menor - nombre del padre/tutor: _____
Apellido Primer Nombre Inicial

Fecha de nacimiento padre/tutor: ___/___/___ N.° de seguro social delpadre _____ - _____ - ____
opcional

Dirección: _____ Ciudad: _____ Código Postal: _____

Grado: _____ Maestro del salón de clases: _____ Escuela: _____

IMPORTANTE Número de teléfono de casa del padre/tutor: _____ Celular: _____ Trabajo: _____

Contacto de emergencia: _____ Número de contacto de emergencia: _____
(en caso de no ser el jefe de familia)

Mi hijo(a) tendrá 11 años o más el día de la clínica de vacunación programada: SÍ ☐ NO ☐

Marque SÍ o NO en todas las preguntas a continuación para determinar si su hijo puede recibir las vacunas que se ofrecen en la escuela. La enfermera que administra la vacuna revisará esta información el día de la clínica de vacunación.	SÍ	NO
¿Su hijo(a) alguna vez ha tenido una reacción alérgica grave a cualquier componente de una vacuna u hongo?	☐	☐
En el pasado ¿su hijo(a) alguna vez ha tenido una reacción grave a una dosis anterior de la vacuna Tdap, VPH o antimeningocócica?	☐	☐
¿Experimentó su hijo un coma, disminución del nivel de conciencia o convulsiones prolongadas o múltiples dentro de los siete días posteriores a una dosis de DTP, DTaP o Tdap?	☐	☐
¿Su hijo padece de epilepsia u otro problema del sistema nervioso; alguna vez ha presentado inflamación grave o dolor intenso después de una dosis anterior de DTP, DTaP, DT o Td; o alguna vez ha padecido el síndrome de Guillain-Barré (GBS)? En caso afirmativo, consulte a su médico acerca de recibir la vacuna Tdap. (Es posible que se requiera una nota para proceder en el entorno escolar)	☐	☐
¿Está embarazada su hija? En caso afirmativo, su hijo no recibirá la vacuna contra el VPH, pero puede recibir las otras vacunas.	☐	☐

Si respondió SÍ a las preguntas, es posible que esta(s) vacuna(s) no sea segura para su hijo(a) y él/ella NO recibirá estas vacunas en la escuela. Si su hijo/a tiene una alergia grave que pone en peligro su vida, hable con el médico de su hijo/a antes de dar su consentimiento para la vacunación.

AVISO DE CONSENTIMIENTO PRESUNTO PARA LA PRUEBA DE VIH Y DE HEPATITIS B O C

El artículo 32.1-45.1 enmendado del Código de Virginia (1950) exige que el VDH realice el siguiente aviso:
1. Si algún profesional de la salud o empleado del VDH estuviera expuesto directamente a la sangre o los fluidos corporales de su hijo de manera tal que se puedan transmitir enfermedades, entiendo que la ley exige que mi hijo brinde una muestra de sangre venosa para realizar pruebas adicionales. Entiendo que las pruebas que se realizarán son para detectar infecciones por el virus de la inmunodeficiencia humana (VIH) y por hepatitis B y C. Un médico u otro proveedor de atención médica le informará el resultado de la prueba. 2. Si su hijo estuviera expuesto directamente a la sangre o los fluidos corporales de un profesional de la salud o empleado del VDH de manera tal que se puedan transmitir enfermedades, se analizará la sangre de la persona para detectar infecciones por el virus de la inmunodeficiencia humana (VIH) y por hepatitis B y C. Un médico u otro proveedor de atención médica les informará a usted y a la persona el resultado de la prueba.

*** Seguro *:** Responda lo siguiente: Esta información es requerida para fines de financiamiento federal para las vacunas de VFC.

***Nota:** Se le administrarán las vacunas a su hijo(a) sin costo alguno para usted si su hijo(a) es elegible para el Programa de Vacunas Infantiles (VFC). Si su hijo(a) tiene cobertura de un plan de seguro médico privado, el Departamento solicitará el reembolso de todos los costos permisibles relacionados con la administración de la vacuna. **Su hijo(a) no será vacunado si no proporciona toda la información del seguro médico solicitada a continuación.**

Mi hijo:
( ) no está asegurado (por un seguro privado, Medicaid o FAMIS)
( ) es indio americano o nativo de Alaska
( ) tiene MCO de Medicaid con: Virginia Premier, Optima Community Care, Anthem Healthkeepers Plus, Molina Healthcare, United Healthcare Community Plan o Aetna Better Health (encierre en un círculo su plan)
Número de póliza que aparece en su tarjeta: _____ ¿Es este un plan FAMIS? ☐Si ☐No
( ) tiene Medicaid o FAMIS (encierre en un círculo su plan) que no es un plan MCO: _____
( ) tiene otro seguro no mencionado anteriormente (especifique el nombre de la a seguranza) _____ Núm. de identificación de la póliza _____
Nombre del titular de la póliza _____
Adjunte una copia del anverso y reverso de la tarjeta del seguro o complete la siguiente información:
Dirección de la compañía de seguros _____
Número de teléfono de la compañía de seguros _____

Autorizo al VDH a divulgar los registros necesarios para apoyar la solicitud de pago de Medicare, Medicaid, y otros beneficios de atención médica. Solicito al tercer pagador que pague cualquier beneficio autorizado a VDH en mi nombre.

Oficina de Privacidad y Seguridad

Autorización para la divulgación de información médica protegida

El presente consentimiento autoriza al Departamento de Salud de Virginia (VDH) a divulgar información médica personal a las personas u organizaciones que he indicado.

- Entiendo que la prestación de tratamiento para mi hijo no podrá depender de que yo firme esta autorización.
- Cualquier información médica que haya sido divulgada por mi hijo o por mí ya no estará protegida por esta autorización.
- Se incluirá el original o una copia de la autorización en el registro médico de mi hijo.
- Tengo derecho a revocar esta autorización en cualquier momento, excepto en la medida en que se hayan tomado medidas antes de que yo solicitara la retención del registro médico. Se debe presentar la solicitud por escrito, y esta entrará en vigencia a partir de la fecha de entrega al proveedor que tenga mis registros médicos.
- Autorizo al VDH a divulgar la información médica de mi hijo a su médico de atención primaria y a la escuela.
- Entiendo que los registros de vacunación de mi hijo se conservarán por un plazo de 21 años después del nacimiento.
- Entiendo que se entregará este documento al departamento de salud pública, quien lo conservará, y la escuela no conservará dicho documento.

☐ Marque la casilla si desea recibir una copia de la Notificación de las Prácticas de Privacidad del Departamento de Salud de Virginia.

CONSENTIMIENTO PARA LA VACUNACIÓN CONTRA EL VPH DEL NIÑO:

☐Mi hijo NUNCA ha sido vacunado contra el VPH. **Nota: Su hijo necesitará dos dosis: la primera dosis ahora y la segunda dosis 6 meses después de la dosis 1. NOTA: los niños con ciertas afecciones médicas pueden requerir tres dosis. Consulte con su proveedor para evaluar la necesidad de una tercera dosis.**

☐Mi hijo(a) ha recibido la primera dosis de la vacuna contra el VPH. **Nota: la segunda dosis debe recibirse 6 meses después de la dosis 1.**

He leído la Declaración de Infomación de Vacunación (VIS) de 2021 para la vacuna contra el VPH. Entiendo los riesgos y beneficios, y doy mi consentimiento al Departamento de Salud y su personal autorizado para que mi hijo(a), mencionado en la parte superior de este formulario reciba la vacuna contra el VPH (inyección). **Si es necesario, doy mi consentimiento para que mi hijo(a) reciba la segunda dosis aproximadamente seis meses después de la primera dosis.**

Firma del padre o tutor legal: X _____ **Fecha:** ___ / ____ / ___

CONSENTIMIENTO PARA LA VACUNA MenACWY DEL NIÑO:

He leído la Declaración de Información sobre Vacunación (VIS) de 2021 para la Vacuna MenACWY. Entiendo los riesgos y beneficios, y doy mi consentimiento al Departamento de Salud y a su personal autorizado para que mi hijo(a), mencionado en la parte superior de este formulario reciba la vacuna antimeningocócica ACWY (inyección).

Firma del padre o tutor legal: X _____ **Fecha:** ___ / ____ / ___

CONSENTIMIENTO PARA LA VACUNA Tdap DEL NIÑO:

He leído la Declaración de Información sobre Vacunación (VIS) de 2021 para la Vacuna Tdap. Entiendo los riesgos y beneficios, y doy mi consentimiento al Departamento de Salud y a su personal autorizado para que mi hijo(a), mencionado en la parte superior de este formulario reciba la vacuna Tdap (inyección).

Firma del padre o tutor legal: X _____ **Fecha:** ___ / ____ / ___

Envíe una copia del registro de vacunación de mi hijo a su médico a la siguiente dirección.

Nombre del Médico _____ *Dirección postal* _____ *Ciudad* _____ *Estado* _____ *Código Postal* _____

SOLO PARA USO DEL DEPARTAMENTO DE SALUD					
Date	Item code	Fund Source	Lot Number	Vaccine Administration Site	Provider #
	Tdap	VFC STF		RA LA	
	MenACWY	VFC STF		RA LA	
	HPV #1	VFC STF		RA LA	
	HPV #2	VFC STF		RA LA	
		VFC STF		RA LA	
Comments					
Provider Name/Signature and Date					