14+ Years Patient Preventative Health Form

Patient Name _____ Date of Birth: _____

Cell phone: _____ Current Date: _____ Current Age: _____

SOCIAL HISTORY

With whom do you live? (Check all that apply)

☐ Mother ☐ Stepmother ☐ Brother(s) Ages: _____ ☐ Other:_____
☐ Father ☐ Stepfather ☐ Sister(s) Ages: _____ _____

During the past year, have there been any major changes in your family (Check all that apply)

☐ Marriage ☐ Loss of job ☐ Births ☐ Other:_____
☐ Separation ☐ Moved ☐ Serious Illness _____
☐ Divorce ☐ New School ☐ Deaths _____

SCHOOL & ACTIVITIES

*1. Where do you go to school and what grade are you in?*_____
*2. What do you like most about school?*_____
3. Over the past year, what have most of your grade been? ☐A's ☐B's ☐C's ☐ D's ☐F's
4. Do you have any trouble focusing or concentrating at school? ☐Yes ☐No
5. Have you ever thought, or have you been told that you have a learning problem? ☐Yes ☐No
6. Have you ever been in trouble at school? _____
7. Approximately how many days of school have you missed this year? _____
*8. What activities are you involved in?*_____
9. What do you typically do after school? _____
10. Have you ever been bullied in school? _____

HEALTH CONCERNS (Check any items which concern you)

☐ Headaches or migraines
☐ Dizzy spells or fainting
☐ Hearing or vision
☐ Mouth/teeth/breath
☐ Skin problems/acne
☐ Muscle or joint pain
☐ Height or weight
☐ Diet/food/appetite
☐ Frequent colds
☐ Allergies
☐ Neck/back
☐ Nose/throat
☐ Coughing or wheezing
☐ Difficulty Breathing
☐ Chest pain
☐ Heart Trouble
☐ Diarrhea or Constipation
☐ Frequent of painful urination
☐ Wetting the bed
☐ Stomach Aches
☐ Nausea or vomiting
☐ Breasts
☐ Sexual organs/genitals
☐ Menstruation/periods
☐ Discharge from vagina/penis
☐ Physical or sexual abuse
☐ Violence/personal safety
☐ Anxiety or nervousness
☐ Constant Tiredness
☐ Sad or crying frequently
☐ Sleeping problems
☐ Feeling down/depressed
☐ Stress at home or school
☐ Anger or temper
☐ Boyfriend/girlfriend
☐ Making friends
☐ Cancer
☐ Dying
☐ Other:_____

MEDICATIONS

Are you currently taking and of the following medications?
Prescriptions: _____ ☐ Check if none
*Over the counter:*_____ ☐ Check if none
*Vitamins/supplements:*_____ ☐ Check if none

PERSONAL SAFETY

1. Do you wear a helmet when you rollerblade, skateboard, or ride bikes/motorcycles? ☐ Yes ☐No
2. Do you wear a seat belt when you ride in or drive a car, truck or van? ☐ Yes ☐No
3. Do you or anyone you live with have a gun, rifle, or other firearm? ☐ Yes ☐ No

4. Are you worried about violence or your safety? ☐Yes ☐No
5. In the past year, have you carried a gun, knife, or other weapon for protection? ☐Yes ☐No
6. Have you ever been in trouble with the law? ☐Yes ☐No
7. Have you ever been in a physical fight? ☐Yes ☐No
8. Have you ever been physically, sexually, or emotionally abused? ☐Yes ☐No
9. Do you talk on your cell phone or text while driving? ☐Yes ☐No

HEALTH INFORMATION AND HABITS

1. Have you seena dentist in the last year? How often do you brush your teeth? _____ ☐Yes ☐No
2. Do you wear sunscreen? ☐Yes ☐No
3. How many times do you exercise per week? ____ *What do you do for exercise?*_____
4. Do you have any physical problems that limit how much you can exercise? ☐Yes ☐No
5. Are you satisfied with the size or shapy of your body, or your physical appearance? ☐Yes ☐No
6. Have you ever tried to lose weight by throwing up or starving yourself? ☐Yes ☐No
7. Do any of your friends drink or use drugs? ☐Yes ☐No
8. Does anyone you live with smoke or chew tobacco? ☐Yes ☐No
9. Have you ever tried any of the following substances?

☐ *Alcohol* ☐ *Chewing tobacco* ☐*Stimulants (caffeine, energy drinks)*
☐ *Diet Pills* ☐ *Marijuana* ☐*Someone else's prescriptions (such as*
☐ *Cigarettes* ☐ *Sniffing.inhalant* *ADHS or anti-anxiety medications)*

10. Have you ever ridden in a car with someone who was drinking alcohol or using drugs? ☐Yes ☐No
11. Does anyone in your family drnk or take drugs so much that it worries you? ☐Yes ☐No
12. Are you attracted to: ☐Males ☐Females ☐Both ☐Not Sure
13. Do you date? ☐Yes ☐No
14. Have you ever had any sexual experiences (if yes, how old were you the first time? _____*)* ☐Yes ☐No
15. Are you worried about getting pregnant (females) or gettng someone else pregnant (males)? ☐Yes ☐No
16. Have you ever been forced to do something sexual that you did not want to do? ☐Yes ☐No

EMOTIONS AND SELF

*1. What four words best describe you?*_____
2. If you could change one thing about your life or yourself what would it be? _____
_____
3. Do you have enough responsibility? ☐Yes ☐No *4. Do you have enough freedom?* ☐Yes ☐No
5. Do you have enough privacy? ☐Yes ☐No *6. Have you had fun recently?* ☐Yes ☐No
7. Have you often felt very sad or down in the past few weeks? ☐Yes ☐No
8. Have you seriously thought about running away from home? ☐Yes ☐No
9. Have you seriously thought about hurting yourself or another person? ☐Yes ☐No
10. Have you ever thought about killing yourself? ☐Yes ☐No
11. When you get angry, do you ever get violent? ☐Yes ☐No
12. Do you think that your parents/guardians listen to you and take your feelings seriously? ☐Yes ☐No
13. Is there anything you would like to change about your family? ☐Yes ☐No
14. Whom do you talk to when things aren't going well? _____
15. Have you or anyone in your family ever been in counseling? ☐Yes ☐No
16. Do you think counseling would be helpful for you or anyone in your family? ☐Yes ☐No

FOR FEMALES

1. Have your periods started? If yes, how old were you? ___ *When was your last one?*_____ ☐Yes ☐No
2. Are your periods regular (monthly)? ☐Yes ☐No *Do you typically have cramps?* ☐Yes ☐No

FOR EVERYONE

Have you had any health problems in the last 12 months? _____
*What would you like to talk about today?*_____

Pre-Participation Physical Evaluation

PPE

Kansas State High School Activities Association • 601 SW Commerce Place • PO Box 495 • Topeka, KS 66601 • 785-273-5329

HISTORY FORM *(should be filled out by the student and **parent/guardian** prior to the physical examination)*

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Home Address _____ Phone _____ - _____

Personal physician _____ Parent Email _____

PPE is required annually and shall not be taken earlier than May 1 preceding the school year for which it is applicable.

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines, inhalers, and supplements (herbal and nutritional) that you are currently taking: _____

_____ ☐ No Medications

Do you have any allergies? ☐Yes ☐No If yes, please identify specific allergy below.

☐Medicines _____ ☐Pollens _____ ☐Food _____ ☐Stinging Insects _____

What was the reaction? _____

Explain "Yes" answers below. Circle questions you don't know the answers to.

General Questions	Yes	No
1. Have you had a medical condition or injury since your last check up or sports physical?		
2. Has a doctor ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
4. Have you ever spent the night in the hospital?		
5. Have you ever had surgery?		
Heart Health Questions About You	**Yes**	**No**
6. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
8. Does your heart ever race or skip beats (irregular beats) during exercise?		
9. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other: _____		
10. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
11. Do you get lightheaded or feel more short of breath than expected during exercise?		
12. Have you ever had an unexplained seizure?		
13. Do you get more tired or short of breath more quickly than your friends during exercise?		
Heart Health Questions About Your Family	**Yes**	**No**
14. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
15. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
Bone And Joint Questions	**Yes**	**No**
18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
19. Have you ever had any broken or fractured bones or dislocated joints?		
20. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
21. Have you ever had a stress fracture?		
22. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
23. Do you regularly use a brace, orthotics, or other assistive device?		
24. Do you have a bone, muscle, or joint injury that bothers you?		
25. Do any of your joints become painful, swollen, feel warm, or look red?		
26. Do you have any history of juvenile arthritis or connective tissue disease?		

Medical Questions	Yes	No
27. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
28. Have you ever used an inhaler or taken asthma medicine?		
29. Is there anyone in your family who has asthma?		
30. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
31. Do you have groin pain or a painful bulge or hernia in the groin area?		
32. Have you had infectious mononucleosis (mono) within the last month?		
33. Do you have any rashes, pressure sores, or other skin problems?		
34. Have you had a herpes or MRSA skin infection?		
35. Have you ever had a head injury or concussion? If yes, how many? _____ What is the longest you've been held out of sports or school? _____ When were you last released? _____		
36. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
37. Do you have a history of seizure disorder?		
38. Do you have headaches with exercise?		
39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling (Stinger/Burner/Pinched Nerve)?		
40. Have you ever been unable to move your arms or legs after being hit or falling?		
41. Have you ever become ill while exercising in the heat?		
42. Do you get frequent muscle cramps when exercising?		
43. Do you or someone in your family have sickle cell trait or disease?		
44. Have you had any problems with your eyes or vision?		
45. Have you had any eye injuries?		
46. Do you wear glasses or contact lenses?		
47. Do you wear protective eyewear, such as goggles or a face shield?		
48. Do you worry about your weight?		
49. Are you trying to or has anyone recommended that you gain or lose weight?		
50. Are you on a special diet or do you avoid certain types of foods?		
51. Have you ever had an eating disorder?		
52. Do you have any concerns that you would like to discuss with a doctor?		
Females Only	**Yes**	**No**
53. Have you ever had a menstrual period?		
54. If yes, are you experiencing any problems or changes with athletic participation (i.e., irregularity, pain, etc.)?		
55. How old were you when you had your first menstrual period?		
56. How many periods have you had in the last 12 months?		
Explain "yes" answers here		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Rev. 1/15

Pre-Participation Physical Evaluation PPE

Kansas State High School Activities Association • 601 SW Commerce Place • PO Box 495 • Topeka, KS 66601 • 785-273-5329

PHYSICAL EXAMINATION FORM

Name: _____ **Date of birth:** _____

Date of recent immunizations: Td _____ **Tdap** _____ **Hep B** _____ **Varicella** _____ **HPV** _____ **Meningococcal** _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
- Do you feel stressed out or under a lot of pressure?
- Do you ever feel sad, hopeless, depressed, or anxious?
- Do you feel safe at your home or residence?
- Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
- During the past 30 days, did you use chewing tobacco, snuff, or dip?
- Do you drink alcohol or use any other drugs?
- Have you ever taken anabolic steroids or used any other performance supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you wear a seat belt and use a helmet?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight Male ☐ Female ☐	BP (reference gender/height/age chart)**** / (/) Pulse	
Vision R 20/ L 20/ Corrected: Yes ☐ No ☐		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Gross Hearing		
Lymph nodes		
Heart * • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)**		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic***		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. **Consider GU exam if in private setting. Having third party present is recommended.
***Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.
****Chart found in: The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents. Pediatric BP mobile application can also be used.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

*Reason _____

Recommendations _____

_____

I have examined the above-named student and student history and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of healthcare provider (print/type)_____ Date _____

Address _____ Phone _____

Signature of healthcare provider_____, MD, DO, DC, PA-C, APRN
(please circle one)

Rev. 1/15

PRE-PARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart for their records).

Date of Exam:				
Name:				Date of Birth:
Sex:	Age:	Grade:	School:	Sport(s):

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

Do you have any allergies: Yes ☐ No ☐ If yes, please identify specific allergy below:

☐ Medicines: ☐ Pollens: ☐ Food: ☐ Stinging Insects:

Explain "Yes" answers below. Circle questions you do not know the answer to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐High blood pressure ☐ A heart murmur ☐High cholesterol ☐ A heart infection ☐Kawasaki disease ☐ Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males) or spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with the doctor?		
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "Yes" answers here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete:	**Signature of Parent(s) or Guardian:**	**Date:**

PRE-PARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name:	Date of Birth:

Physician Reminders:

1. Consider additional questions on more sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplements?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Questions 5-14).

EXAMINATION

Height:	Weight:	☐ Male	☐ Female
BP: / (/)	Pulse:	Vision: R 20/ L 20/	Corrected: ☐ Yes ☐ No

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal pulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)**		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic***		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

* Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam; **Consider GU exam if in private setting. Having third party present is recommended.
***Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction.

☐ Cleared for all sports without restriction **with recommendations for further evaluation or treatment for**:

☐ Not Cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports (please list):

Reason:

Recommendations:

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (type/print):	Date:
Address:	Phone:
Signature of Physician (MD/DO/ARNP/PA/Chiropractor):	

GENERAL VACCINE CONSENT FORM

Patient's Name: _____ Patient's Date of Birth: _____

IMMUNIZATION SCREENING QUESTIONNAIRE		
1. Have you had a fever greater than 101®F within the past 24 hours?	Yes ☐	No ☐
2. Does the patient have allergies to medications, food, a vaccine component, or latex?	Yes ☐	No ☐
3. Has the patient had a serious reaction to a vaccine in the past?	Yes ☐	No ☐
4. Has the patient had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or blood disorder? Is he/she on long-term aspirin therapy?	Yes ☐	No ☐
5. If the patient to be vaccinated is between the ages of two and 4 years, has a healthcare provider told you that the child has wheezing or asthma in the past 12 months?	Yes ☐	No ☐
6. History of Guillain-Barre syndrome (GBS)?	Yes ☐	No ☐
7. If the patient is a baby, have you ever been told he or she has had intussusceptions?	Yes ☐	No ☐
8. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	Yes ☐	No ☐
9. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes ☐	No ☐
10. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	Yes ☐	No ☐
11. In the past year, has the patient received a transfusion of blood or blood products or been given immune (gamma) globulin?	Yes ☐	No ☐
12. Is the patient pregnant or is there a chance she could become pregnant during the next month?	Yes ☐	No ☐
13. Has the patient received vaccinations in the past 4 weeks?	Yes ☐	No ☐
INFLUENZA ONLY		
14. If under the age of 9, has the patient received a flu vaccine before?	Yes ☐	No ☐
15. Has the patient taken any antiviral medication within the previous 48 hours?	Yes ☐	No ☐
HPV ONLY (FEMALES ONLY)		
16. When was your last period?		

☐ DT ☐ DTaP ☐ Tdap ☐ Td ☐ HepA ☐ HepB ☐ Hib ☐ Varicella

☐ Meningococcal ☐ Meningococcal B ☐ MMR ☐ PCV13 ☐ PCV23 ☐ Polio/IPV ☐ Rotavirus

☐ Influenza Shot ☐ FluMist ☐ HPV4* ☐ HPV9*

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked above. I have read, had explained to me, and understand the information in the VIS(s). I understand the benefits and risks of all vaccines to be given today. I asked that the vaccine(s) checked above be given to me or to the person named above for whom I am authorized to make this request. I fully release and discharge, Leawood Pediatrics, its affiliates, officers, directors, and employees from any liability related to the administration of these vaccines. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above.

*_**If you are receiving either HPV shot today, we require you to wait 15 minutes after receiving the shot to ensure not reaction.**_

Patient/Guardian Signature: _____ Date: _____

If legal guardian, print name: _____

OFFICE USE ONLY

Date booster required (if applicable): _____ **Give card to parent with date

VACCINE	DOSE #	EXT	SITE	ROUTE	LOT #	EXP DATE
		RT LT	Deltoid Vastus Lat Upper Arm Thigh	IM SC Oral		
		RT LT	Deltoid Vastus Lat Upper Arm Thigh	IM SC Oral		
		RT LT	Deltoid Vastus Lat Upper Arm Thigh	IM SC Oral		
		RT LT	Deltoid Vastus Lat Upper Arm Thigh	IM SC Oral		
		RT LT	Deltoid Vastus Lat Upper Arm Thigh	IM SC Oral		
Name & Title of Vaccine Administrator					Date	

How can I help protect my child from **bacterial meningitis?**

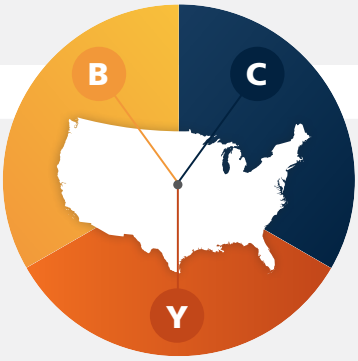
One type of bacterial meningitis is meningococcal meningitis, which is a form of meningococcal disease.

Invasive meningococcal disease is an acute, severe illness caused by the bacterium *Neisseria meningitidis (N. meningitidis),* also known as meningococcus [muh-ning-goh-KOK-us].

Meningitis is a rare but potentially life-threatening condition caused by inflammation of the protective membranes ("meninges") covering the brain and spinal cord. This inflammation is usually caused by infection with viruses or bacteria, including *N. meningitidis*.

There are 13 known groups of the bacterium, but 5 of them — A, B, C, W, and Y — cause most of the meningococcal disease worldwide.

Three meningococcal groups — **B, C, and Y** — cause most of the illness in people over the age of 11 in the United States. Each of these groups is responsible for about a third of all cases.



There were about 550 cases of meningococcal disease in the United States in 2013.

Risk Factors for Bacterial Meningitis

Infants younger than 1 year and adolescents and young adults 16-23 years of age, people without a spleen, people with certain immune system problems, living in close quarters (such as college dormitories or military barracks), and smoking (active or passive).

How Bacterial Meningitis Is Spread

Close contact can help spread the bacterium through exchanges of saliva and secretions from the nose or throat, including:

Coughing | Sneezing | Kissing

Symptoms of Bacterial Meningitis

Symptoms can progress rapidly — within 24 hours — and can become serious, possibly fatal.

24

✔ Fever ✔ Headache ✔ Stiff Neck

Additional symptoms may include: nausea, vomiting, sensitivity to light, confusion.

Impact of Bacterial Meningitis

11 to **19%** of survivors of meningococcal disease will have long-term consequences, including deafness, nervous system problems, brain damage, or loss of limbs.

About 10-15% of people infected with meningococcal disease will die.

Vaccines to Help Prevent Bacterial Meningitis

According to the Centers for Disease Control and Prevention (CDC), keeping up-to-date with recommended vaccines is the best defense against acquiring bacterial meningitis, although vaccination may not result in protection in all recipients.

There are separate vaccines for meningococcal groups ACWY disease **(MenACWY disease)** and meningococcal group B disease **(MenB disease).**

MenACWY Vaccine

- There are quadrivalent (4-group) vaccines that help protect against groups A, C, W, and Y. These have been available in the United States since the 1980s.
- The CDC recommends MenACWY vaccination for all adolescents 11-12 years of age, with a booster at age 16 (before the period of increased risk).

MenB Vaccine

- MenB disease is different from MenACWY disease, so a different type of vaccine was needed.
- MenB vaccines were not available in the United States until October 2014.
- According to the CDC, MenB vaccination may be administered to adolescents and young adults 16-23 years of age, preferably 16-18 years of age, to help protect against MenB disease.

There are 2 different vaccines that can help protect your child against the 5 common meningococcal groups.

Talk to your child's healthcare provider about: ✔ MenACWY vaccination ✔ MenB vaccination

SPREAD #HPVFACTS

4 THINGS A PARENT NEEDS TO KNOW ABOUT HUMAN PAPILLOMAVIRUS (HPV).

The more we learn about health risks for our children, the more we can do to help protect them as they grow up. **That's why it's so important to get the facts about HPV.**

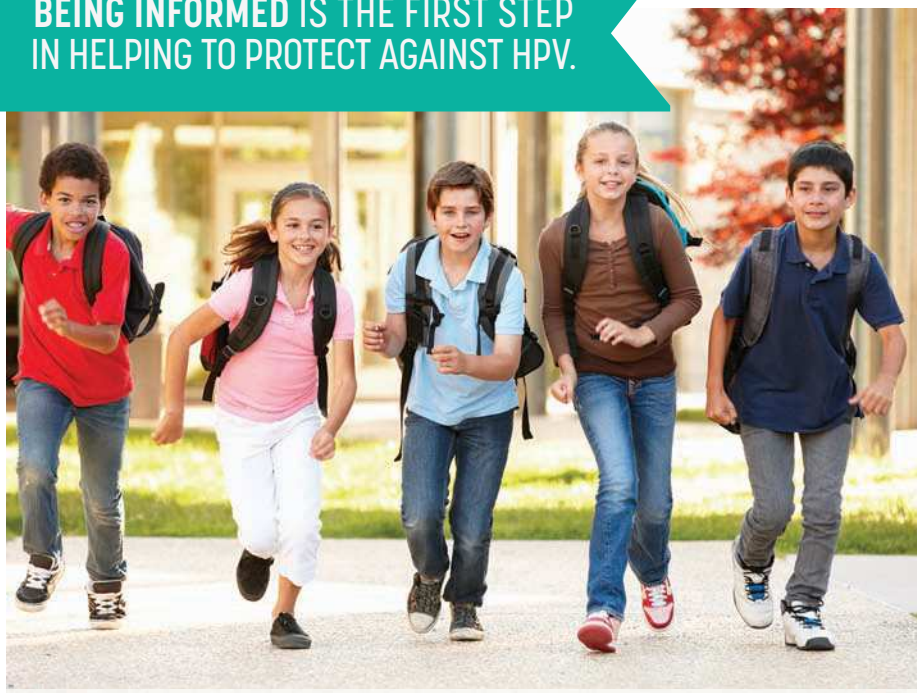
1

HPV CAN BE **SERIOUS.**

HPV CAN CAUSE CERTAIN **PRECANCERS, CANCERS,** AND OTHER DISEASES.

These can develop very slowly and may not even occur until later in life.

BEING INFORMED IS THE FIRST STEP IN HELPING TO PROTECT AGAINST HPV.



The persons depicted in these materials are models being used for illustrative purposes only.

2

HPV AFFECTS **BOTH** GENDERS.

Both males and females are affected by HPV. Exposure to the virus can happen with any kind of adolescent experimentation that involves genital contact with someone who has HPV — intercourse isn't necessary, but it is the most common way to get the virus.

IT'S IMPORTANT TO **HELP PROTECT CHILDREN BEFORE THEY ARE AT RISK.**

3

YOU **CAN'T TELL** IF SOMEONE HAS HPV.

Many people who have HPV **don't even know it** because HPV often has no signs or symptoms.

4

THERE IS **NO TREATMENT** FOR HPV INFECTION.

HOWEVER, THERE ARE WAYS TO HELP PROTECT YOUR CHILD FROM HPV-RELATED CANCERS AND DISEASES.

EDUCATION IS THE FIRST STEP IN HELPING TO PROTECT YOUR KIDS FROM CERTAIN HPV-RELATED CANCERS AND DISEASES LATER IN LIFE.

You've read some of the surprising facts about HPV.
The statistics below may surprise you even more.

APPROXIMATELY
14 MILLION PEOPLE
will become newly infected
EACH YEAR. AND ABOUT
50% OF NEW INFECTIONS
OCCUR IN 15- TO 24-YEAR-OLDS.

FOR MOST PEOPLE, HPV CLEARS ON ITS OWN.
But, for others who don't clear the virus, it could cause certain precancers, cancers, and other diseases.

EACH DAY in the United States,
33 WOMEN are diagnosed with HPV-related
CERVICAL CANCER.

Although there are more than 40 genital types of HPV, only certain types can cause

HPV-RELATED CANCERS AND DISEASES:

- ANAL CANCER
- GENITAL WARTS
- CERVICAL CANCER
- VULVAR CANCER
- VAGINAL CANCER

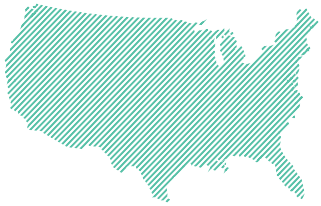
WHAT SHOULD I KNOW?

- **HUMAN PAPILLOMAVIRUS** is a virus that can cause certain cancers and diseases in both males and females.
- Exposure to HPV can happen with any kind of adolescent experimentation that involves genital contact with someone who has HPV — intercourse isn't necessary, but it is the most common way to get the virus.
- Because **HPV often has no visible signs or symptoms,** anyone can get the virus or pass the virus on without even knowing it. And there's no way to predict who will or won't clear the virus.

WHAT CAN I DO ABOUT IT?

Protection starts with knowing the facts.
Now that you're armed with more information, talk to your child's doctor to see if vaccination is right for your child.

For more information, visit **HPV.COM**



EVERY HOUR, there are an estimated
40 NEW CASES of
GENITAL WARTS
in the United States.

MERCK

PROVIDED AS AN EDUCATIONAL RESOURCE BY MERCK.

SPREAD #HPVFACTS