UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

Dear Parent,

Miami-Dade County Public Schools has joined in collaboration with the University of Miami's Pediatric Mobile Clinic to provide required immunizations to your child. To receive this service, **please complete the information below and sign at the bottom.** This service will be free of charge.

Student Information

First name:_____**Middle Initial:**_____**Last Name:** _____

Birth Date: Month:_____Day_____Year_____

Parent/ Guardian (Emergency Contact)

Full Name:_____**Relationship to patient:**_____

Phone Numbers: Home_____**Cell:** _____

VACCINE INFORMATION AND CONSENT

Your child may need immunizations which will be administered on the mobile clinic. As with any medicine, vaccines have a small risk of side effects. Potential side effects associated with each vaccine as reported by the Centers for Disease Control (CDC) can be found through vaccine information statements listed on the following website: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. We administer the following recommended vaccines:

- **Diphtheria, Tetanus, and Pertussis (DTaP)**
- **Chickenpox (Varicella)**
- **Haemophilus Influenza Type B (Hib)**
- **Measles, Mumps, and Rubella (MMR)**
- **Pneumococcal Vaccine**
- **Hepatitis A or B**
- **Polio (IPV)**
- **Tetanus and Diphtheria (Td) or Tetanus, Diphtheria, and Pertussis (TDaP)**
- **Influenza**
- **Meningococcal**
- **HPV**

****NOTE: ALL REQUIRED AND RECOMMENDED VACCINATIONS WILL BE GIVEN UNLESS OTHERWISE SPECIFIED BY THE PARENT OR GUARDIAN.**

CONSENT BY PARENT OR GUARDIAN TO VACCINATE THE STUDENT

I, the parent or guardian of_____, agree for my child to receive the required / recommended vaccinations. By signing this University of Miami consent to treatment form, I acknowledge that these vaccinations will be provided to my child without limitation. If I do not wish to have specific vaccines for my child, I will indicate below.

I would like to opt out of the following vaccines for my child: ☐

Parent/Guardian Signature Parent/Guardian Name (Print)	Parent/Guardian Signature Parent/Guardian Name Signature	Date	Time

For further information contact Pediatric Mobile Clinic at 305-243-6407. All vaccinations will be recorded in the Florida SHOTS registry.

UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

Estimados Padres,

Las escuelas del Condado de Miami-Dade se han unido en colaboración con la Clínica Pediátrica Móvil de la Universidad de Miami para proveer las vacunas requeridas para registrarse y permanecer en la escuela. **Para recibir este servicio por favor complete y firme esta forma. Este servicio es completamente gratuito.**

Información sobre el Estudiante

Nombre:_____**Apellido:** _____

Fecha de Nacimiento: Mes:_____Dia _____ Ano _____

Padres / Guardianes (Contacto de Emergencia)

Nombre / Apellido:_____**Relación con el paciente:**_____

Números de Teléfono: Casa_____**Celular:** _____

INFORMACION DE VACUNAS Y CONSENTIMIENTO

Su hijo/hija necesita vacunas que serán administradas en la clínica móvil. Como con cualquier medicamento, vacunas tienen un riesgo mínimo de efectos secundarios. Información sobre efectos secundarios que se pueden presentar con cada vacuna, y reportados por el Centro para el Control y la Prevención de Enfermedades (CDC) se pueden encontrar en la siguiente pagina web: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. La clínica móvil provee las siguientes vacunas:

- **Difteria, Tétanos y Tos Ferina (DTaP)**
- **Varicela**
- **Gripe hemofílica tipo B (Hib)**
- **Sarampión, Paperas y Rubéola (MMR)**
- **Vacuna Antineumocócica**
- **Hepatitis A o B**
- **Polio (IPV)**
- **Tétanos y Difteria (Td) o Tétanos, Difteria, y Tos Ferina (TDaP)**
- **Influenza**
- **Meningococo**
- **HPV**

**NOTA: TODAS LAS VACUNAS REQUERIDAS Y RECOMENDADAS SERAN ADMINISTRADAS A MENOS DE QUE LOS PADRES/GUARDIANES INDIQUEN DE OTRA MANERA.

CONSENTIMIENTO POR EL PADRE O GUARDIAN PARA VACUNAR AL ESTUDIANTE

Yo, el padre/madre o guardián de_____, autorizo que mi hijo/hija reciba las vacunas requeridas / recomendadas. Al firmar este formulario de consentimiento de la Universidad de Miami para el tratamiento, reconozco que estas vacunas se proporcionarán a mi hijo sin limitación. Si no deseo tener vacunas específicas para mi hijo, lo indicaré a continuación.

Me gustaría optar por no recibir las siguientes vacunas para mi hijo/hija: ☐

_____ _____ _____ _____

Nombre del padre/guardián (impresión) Nombre del padre/guardián (firma) Fecha Hora

Para más información contacte la Clínica Pediátrica Móvil al 305-243-6407. Todas las vacunas se registrarán en el registro SHOTS de Florida.

UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

Chè paran,

Lekòl Leta Miami-Dade County mete ansanm an kolaborasyon ak Klinik Mobil Pedyatrik University of Miami pou bay pitit ou Vaksinasyon obligatwa yo. Pou resevwa sèvis sa a, tanpri ranpli enfòmasyon ki anba a epi siyen anba. Sèvis sa a se gratis.

Enfòmasyon sou Elèv yo

Premye Non:_____**Non Mitan:**_____**Siyati:** _____

Dat nesans: Mwa:_____Jou_____Ane_____

Paran/ Gadyen (Kontak Ijans)

Non Konplè:_____**Relasyon ak pasyan an:**_____

Nimewo Telefòn: Lakay_____**Selil:** _____

ENFOMASYON SOU VAKSEN AK KONSANTMAN

Pitit ou a bezwen vaksinasyon ki pral administre nan klinik mobil lan. Menm jan ak nenpòt medikaman, vaksen yo gen yon ti risk pou yo gen efè segondè. Efè segondè potansyèl ki asosye avèk chak vaksen jan yo rapòte pa Sant pou Kontwòl Maladi (CDC) ka jwenn nan deklarasyon enfòmasyon sou vaksen ki nan lis sou sit entènèt sa a. https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. Nou administre vaksen sa yo rekòmande:

- **Difteri, tetanòs, ak koklich (DTaP)**
- **Varisèl (Varisèl)**
- **Haemophilus Grip Kalite B (Hib)**
- **Lawoujòl, malmouton, ak ribeyòl (MMR)**
- **Vaksen Pneumococcal**
- **Epatit A oswa B**
- **Polyo (IPV)**
- **tetanòs ak difteri (Td) oswa tetanòs ak difteri ak koclich**
- **(TDaP)**
- **Grip**
- **Menengokòk**
- **HPV**

****Remak: TOUT VAKSINASYON KI OBLIGATWA AK REKÒMAMANDE YO NAP BAY SI OU MENM PARAN OSWA GADYEN AN PA ESPESIFYE.**

KONSANTMAN PARAN OSWA GADYEN POU VAKSINEN ELÈV LA

Mwen,paran oswa gadyen legal la, _____, mwen dakò pou pitit mwen an resevwa vaksen yo made/ rekòmande yo. Le mwen siyen fòm konsantman inivesite Miami sa a pou tretman, mwen rekònet ke yo pral bay pitit mwen vaksinasyon sa yo san limit. Si mwen pa vle gen vaksen espesifik pou pitit mwen an, mwen pral endike sa anba a.

Mwen ta renmen patisipe nan vaksen say yo pou pitit mwen an: ☐

Siyati Paran/Gadyen (Print)	Siyati Paran/Gadyen	Dat	Lè

Pou plis enfòmasyon kontakte pediatric klinik mobil nan 305-243-6407. Tout vaknisyon yo pral anrejistre nan rejis system florida shot la

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Child and Teen Immunization

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to latex, medications, food, or any vaccine?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐	☐	☐
9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
11. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your child's immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have a personal record, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care for your child. Your child will need this important document for the rest of his or her life to enter day care or school, for employment, or for international travel.

Item #R4060 (6/10)

Printed by Immunization Action Coalition • Saint Paul, MN • (651) 647-9009 • www.immunize.org/shop

Nombre del paciente: _____ Fecha de nacimiento: ____/____/____
(mes) (día) (año)

Cuestionario de selección para vacunación de niños y adolescentes

A los padres/tutores: Las siguientes preguntas nos ayudarán a determinar cuáles vacunas le podremos dar hoy a su hijo. Si contesta "sí" a alguna pregunta, eso no siempre quiere decir que no deben vacunar a su hijo. Simplemente quiere decir que hay que hacerle más preguntas. Si alguna pregunta no está clara, pida a su profesional de la salud que se la explique.

	Sí	No	No Sabe
1. ¿Está enfermo hoy el niño?	☐	☐	☐
2. ¿Es alérgico el niño al látex, a algún medicamento, alimento o vacuna?	☐	☐	☐
3. ¿Tuvo alguna vez el niño alguna reacción seria a una vacuna en el pasado?	☐	☐	☐
4. ¿Ha tenido el niño algún problema de salud como enfermedad de los pulmones, del corazón, de los riñones o metabólica (como diabetes), asma o un trastorno de la sangre? ¿Está en terapia de aspirina a largo plazo?	☐	☐	☐
5. Si el niño que va a ser vacunado tiene entre 2 y 4 años de edad, ¿le dijo algún profesional de la salud en los últimos 12 meses que el niño tuvo sibilancias o asma?	☐	☐	☐
6. ¿El niño, uno de sus hermanos o padres, ha tenido convulsiones; ha tenido el niño otros problemas del cerebro o del sistema nervioso?	☐	☐	☐
7. ¿Tiene el niño cáncer, leucemia, SIDA o algún otro problema del sistema inmunológico?	☐	☐	☐
8. En los últimos 3 meses, ¿ha tomado el niño cortisona, prednisona, otros esteroides o medicamentos contra el cáncer, o le han hecho tratamientos de radiación?	☐	☐	☐
9. Durante el año pasado, ¿le hicieron al niño una transfusión de sangre o de productos de la sangre, o le dieron inmunoglobulina o gamaglobulina o algún medicamento antiviral?	☐	☐	☐
10. ¿Está la niña/adolescente embarazada o hay alguna posibilidad de que quede embarazada durante el próximo mes?	☐	☐	☐
11. ¿Le aplicaron alguna vacuna al niño en las últimas 4 semanas?	☐	☐	☐

Formulario llenado por: _____ Fecha: _____

Formulario revisado por: _____ Fecha: _____

¿Trajo el comprobante de vacunación de su hijo? **sí** ☐ **no** ☐

Es importante que tenga un comprobante de vacunación personal de las vacunas de su hijo. Si no lo tiene, pídale al profesional de la salud de su hijo que le dé uno con todas las vacunas que le aplicaron a su hijo. Guárdelo en un lugar seguro y llévelo todas las veces que su hijo reciba atención médica. Su hijo necesitará este documento importante por el resto de su vida para ingresar a la guardería o a la escuela, para empleos o para viajar al extranjero.

Item #R4050 (6/10)

Printed by Immunization Action Coalition • Saint Paul, MN • (651) 647-9009 • www.immunize.org/shop

Healthcare Professionals: Retain this card for your reference. It explains why the 11 questions on the padded "Screening Questionnaire for Child/Teen Immunization" are important to ask your patients.

1. Is the child sick today? *[all vaccines]*

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1, 2). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Does the child have allergies to latex, medications, food, or any vaccine? *[all vaccines]*

History of anaphylactic reaction such as hives (urticaria), wheezing or difficulty breathing, or circulatory collapse or shock (not fainting) to latex or from a previous dose of vaccine or vaccine component is a contraindication for further doses. For example, if a person experiences anaphylaxis after eating eggs, do not administer influenza vaccine, or if a person has anaphylaxis after eating gelatin, do not administer MMR, MMRV, or varicella vaccine. A local reaction is not a contraindication. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf. For an extensive table of vaccine components, see reference 3.

3. Has the child had a serious reaction to a vaccine in the past?

[all vaccines] History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. Precautions to DTaP (not Tdap) include the following: (a) seizure within 3 days of a dose, (b) pale or limp episode or collapse within 48 hours of a dose, (c) continuous crying for 3 or more hours within 48 hours of a dose, and (d) fever of 105°F (40°C) within 48 hours of a previous dose. There are other adverse events that might have occurred following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. Has the child had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy? *[LAIV]*

Children with any of the health conditions listed above should not be given the intranasal, live attenuated influenza vaccine (LAIV). These children should be vaccinated with the injectable influenza vaccine.

5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? *[LAIV]*

Children who have had a wheezing episode within the past 12 months should not be given the live attenuated influenza vaccine. Instead, these children should be given the inactivated influenza vaccine.

6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem? *[DTaP, Td, Tdap, TIV, LAIV, MCV4, MMRV]*

DTaP and Tdap are contraindicated in children who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of DTaP and Tdap and a progressive neurologic disorder in a teen is a precaution to the use of Td. For children with stable neurologic disorders (including seizures) unrelated to vaccination, or for children with a family history of seizures, vaccinate as usual (*exception:* children with a personal or family [i.e., parent or sibling] history of seizures generally should not be vaccinated with MMRV; they should receive separate MMR and varicella vaccines). A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give age-appropriate Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (TIV or LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccination, vaccinate with TIV if at high risk for severe influenza complications; 3) MCV4: avoid vaccinating persons unless in recommended risk groups.

7. Does the child have cancer, leukemia, AIDS, or any other immune system problem? *[LAIV, MMR, MMRV, RV, Var]*

Live virus vaccines (e.g., MMR, MMRV, varicella, rotavirus, and the intranasal live, attenuated influenza vaccine [LAIV]) are usually contraindicated in immunocompromised children. However, there are exceptions. For example, MMR is recommended for asymptomatic HIV-infected children who do not have evidence of severe immunosuppression. Likewise, varicella vaccine should be considered for HIV-infected children with age-specific CD4+ T-lymphocyte percentage at 15% or greater and may be considered for children age 8 years and older with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/μL. Immunosuppressed children should not receive LAIV. Infants who have been diagnosed with severe combined immunodeficiency (SCID) should not be given a live virus vaccine, including rotavirus (RV) vaccine. For details, consult the ACIP recommendations (4, 5, 6).

8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? *[LAIV, MMR, MMRV, Var]*

Live virus vaccines (e.g., MMR, MMRV, varicella, LAIV) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. LAIV can only be given to healthy non-pregnant individuals age 2–49 years.

9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, MMRV, Var]*

Certain live virus vaccines (e.g., LAIV, MMR, MMRV, varicella) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations or the current *Red Book* for the most current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines (1, 2).

10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? *[LAIV, MMR, MMRV, Var]*

Live virus vaccines (e.g., MMR, MMRV, varicella, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus (1, 6). Sexually active young women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt of the vaccine (5, 8). On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of disease is imminent (e.g., travel to endemic areas) and immediate protection is needed. Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester (9).

11. Has the child received vaccinations in the past 4 weeks?

[LAIV, MMR, MMRV, Var, yellow fever]

If the child was given either live, attenuated influenza vaccine (LAIV) or an injectable live virus vaccine (e.g., MMR, MMRV, varicella, yellow fever) in the past 4 weeks, they should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at the same time or at any spacing interval.

References:

1. CDC. General recommendations on immunization, at www.cdc.gov/vaccines/pubs/acip-list.htm.
2. AAP. *Red Book: Report of the Committee on Infectious Diseases* at www.aapredbook.org.
3. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
4. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
5. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
6. CDC. Prevention and Control of Influenza—Recommendations of ACIP at www.cdc.gov/flu/professionals/vaccination/.
7. CDC. Excerpt from Guidelines for preventing opportunistic infections among hematopoietic stem cell transplant recipients. *MMWR* 2000; 49 (RR-10), www.cdc.gov/vaccines/pubs/down-loads/b_hsct-recs.pdf.
8. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
9. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants: Recommendations of the ACIP. *MMWR* 2008; 57 (RR-4).

Item #R4060 (6/10)

Printed by Immunization Action Coalition • Saint Paul, MN • (651) 647-9009 • www.immunize.org/shop