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# Pediatric Associates of LaGrange, P.C.

Today's Date: \_\_\_\_\_

P	PATIENT FIRST NAME:			MIDDLE NAME:			LAST NAME:						
	..... MARK THE NAME PATIENT GOES BY .....												
	PATIENT SSN:			PATIENT DOB:			SEX: M    F						
	.....												
	BILL PAYER:			PATIENT LIVES WITH:									
	ADDRESS:			ADDRESS:									
	CITY:			STATE:		ZIP:		CITY:		STATE:		ZIP:	
	.....												
	MOTHER'S CELL PHONE:    -    -			MOTHER'S WORK PHONE:    -    -			HOME PHONE:    -    -						
	FATHER'S CELL PHONE:    -    -			FATHER'S WORK PHONE:    -    -			ALT. PHONE:    -    -						
.....													
A	Mother's Name:			Maiden Name:			Mother's DOB:						
	Mother's Employer:			Mother's SSN:									
	Father's Name:			Father's SSN:			Father's DOB:						
	Father's Employer:												
	PRIMARY INSURANCE:			DAD'S INSURANCE		MOM'S INSURANCE		OTHER:					
	SECONDARY INSURANCE:			DAD'S INSURANCE		MOM'S INSURANCE		OTHER:					
	.....												
	L	NUMBER OF PEOPLE LIVING IN CHILD'S HOUSEHOLD			MOTHER IN HOUSEHOLD: Y    N		FATHER IN HOUSEHOLD: Y    N						
		.....											
		SIBLING:			AGE:			HEALTHY: Y    N					
SIBLING:			AGE:			HEALTHY: Y    N							
SIBLING:			AGE:			HEALTHY: Y    N							
SIBLING:			AGE:			HEALTHY: Y    N							
.....													
S		PERSONS ALLOWED TO BRING CHILD TO OFFICE VISITS FOR TREATMENT					RELATIONSHIP TO PATIENT						
		.....											

# PATIENT MEDICAL HISTORY

**PATIENT NAME:** \_\_\_\_\_

*Please circle if your child has had any of the following:*

- |                  |                          |                         |                          |                   |
|------------------|--------------------------|-------------------------|--------------------------|-------------------|
| Bronchiolitis    | Kidney Disease           | Blackout Spells         | Congenital Heart Disease | Behavior Problems |
| Bronchitis       | Kidney Infections        | Brain Disease or Injury | Neurofibromatosis        | Eye Problems      |
| Persistent Cough | Problems Urinating       | Cerebral Shunt          | Tuberous Sclerosis       | Skin Problems     |
| Wheezing         | Urinary Tract Infections | Headaches               | Chicken Pox              | Immune Problems   |
| Whooping Cough   | Urologic Malformations   | Seizures                | Mumps                    | Thyroid Problems  |
| Allergies        | Constipation             | Staring Spells          | Measles                  | Sleep Problems    |
| Hay Fever        | Diarrhea                 | Broken Bones            | German Measles           | Bleeding Problems |
| Sinusitis        | Excess Weight Gain       | Joint Problems          | Malignancy or Bone       | Eating Problems   |
| Scarlet Fever    | Excess Weight Loss       | High Blood Pressure     | marrow Transplant        | Prematurity       |
| Strep Throat     | Frequent Vomiting        | Treatment with medicine | Solid Organ Transplant   |                   |
| Tonsillitis      | Soiling Pants            | known to raise blood    | Poisoning                |                   |
| Bed Wetting      | Stomach Ache             | pressure                | Meningitis               |                   |

*Please specify any allergies your child has had in the past:* \_\_\_\_\_

*Please list any medical problems, surgeries, specialists:* \_\_\_\_\_

*Please list all medications currently taken:* \_\_\_\_\_

**Hospitalizations:** \_\_\_\_\_

**Circle if your child had any of the following with baby shots (immunizations):** High Fever, Seizure, Leg Swelling, Uncontrollable Screaming, Other \_\_\_\_\_

**Pregnancy, labor, delivery and nursery:** Was your pregnancy planned?      Yes      No

**Circle if you had any of the following during pregnancy:**

- |                                 |                         |                       |                      |
|---------------------------------|-------------------------|-----------------------|----------------------|
| C-Section                       | Labor longer than 1 day | Hepatitis B or C      | Other pain medicines |
| Reason for C-Section            | Early labor             | Syphillis             | Kidney infections    |
| _____                           | Vacuum                  | Gonorrhea             | Other infections     |
| Spinal/Anesthesia               | Forceps                 | High blood pressure   | Medicines other than |
| Infection or fever during labor | Group B Strep           | Alcohol or drug abuse | prenatal vitamins    |
| Water leaking > 1 day           | HIV                     | Cigarette use         | Cigarette Exposure   |

**Circle if the baby had any of the following problems:**

- |                           |              |                      |                              |
|---------------------------|--------------|----------------------|------------------------------|
| Problem right after birth | Infection    | Jaundice             | Longer hosp stay than you    |
| Breathing problems        | Low sugar    | IV or IV antibiotics | Low blood count or anemia    |
| Feeding problems          | Heart murmur | ICU                  | Tube, bag or mask to breathe |

What was the child's birth weight? \_\_\_\_\_ What was the child's Apgar scores? \_\_\_\_\_  
 Was the baby full term? If not, how many weeks early? \_\_\_\_\_ If child stayed in the ICU, where and how long? \_\_\_\_\_  
 Problems while in ICU? \_\_\_\_\_  
 Any signs or symptoms of maternal/paternal depression since child's birth? Y/N Explain: \_\_\_\_\_

**Family History: Circle in anyone in your family has any of the following:**

- |   |                              |                              |                         |                            |
|---|------------------------------|------------------------------|-------------------------|----------------------------|
| Y/N High cholesterol  | Y/N Gallbladder disease      | Y/N Seizures                 | Y/N Eye problems        | Y/N Birth defects          |
| Y/N High blood pressure   | Y/N Hepatitis B,C            | Y/N Migraines                | Y/N Deafness            | Y/N Cancer                 |
| Y/N Rheumatic Fever   | Y/N Thyroid disease          | Y/N Asthma                   | Y/N Allergies           | Y/N Early death            |
| Y/N Kidney stones   | Y/N Diabetes                 | Y/N Cystic Fibrosis          | Y/N Eczema              | Y/N Mental disease         |
| Y/N Congenital kidney disease                                       | Y/N Overweight               | Y/N TB (Tuberculosis)        | Y/N Skin problems       | Y/N Mental retardation     |
| Y/N Kidney disease  | Y/N Excessive weight gain    | Y/N Abnormal fingers or toes | Y/N Cleft lip or palate | Y/N Behavior problems      |
| Y/N Ulcers  | Y/N Height less than 5' 0"   | Y/N Joint disease            | Y/N Bleeding problems   | Y/N Learning problems      |
| Y/N Bowel disease (Ileitis)   | Y/N Height greater than 6'4" | Y/N Crippling arthritis      | Y/N Leukemia            | Y/N Reading problems       |
| Y/N Liver problems  | Y/N Immune problems          | Y/N Sickle cell disease      | Y/N Abnormal teeth      | Y/N Hyperactivity/ADD/ADHD |
| Y/N Alcohol problem   | Y/N Stroke                   | Y/N Blindness                | Y/N Down's Syndrome     | Other _____                |
| Y/N Heart Attack (man less than 40 years/ woman less than 50 years) |                              |                              |                         |                            |

PEDIATRIC ASSOCIATES OF LAGRANGE, P.C.  
LISA P. ALLARDICE, M.D., F.A.A.P.  
DIANA L. HESS, CPNP

PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Associates of LaGrange, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Associates of LaGrange's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Associates of LaGrange reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric Associates of LaGrange's Privacy Officer at 205 Calumet Center Road, LaGrange, GA, 30241.

With my consent, Pediatric Associates of LaGrange may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatric Associates of LaGrange may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Pediatric Associates of LaGrange may e-mail and/or text to me appointment reminders and patient statements. I have the right to request that Pediatric Associates of LaGrange restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting Pediatric Associates of LaGrange's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatric Associates of LaGrange may decline to provide treatment to me.

I authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Pediatric Associates of LaGrange, P.C., for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent or Legal Guardian

\_\_\_\_\_  
Print Patient's Name





Patient Name: \_\_\_\_\_

### Lead Risk Assessment Questionnaire

Circle Yes or No

\*If Yes, please explain

- |  |     |    |       |
|--|-----|----|-------|
| 1. Does your child live in or often visit a house that may have been built before 1978?                                | Yes | No | _____ |
| 2. Does your child live in or often visit a house that is being remodeled or is having paint removed?                  | Yes | No | _____ |
| 3. Does your child live with or often visit another child that has an elevated blood lead level?                       | Yes | No | _____ |
| 4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses it?           | Yes | No | _____ |
| 5. Does your child chew on or eat any non-food items like paint chips or dirt?   | Yes | No | _____ |
| 6. Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead? | Yes | No | _____ |
| 7. Does your child receive medicines such as <i>greta</i> , <i>azarcon</i> , <i>kohl</i> or <i>pay-loo-ah</i> ?        | Yes | No | _____ |

### Risk Factors for Hearing Loss

- |   |     |    |
|---|-----|----|
| 1. Parent or caregiver concern regarding hearing, speech, language, or developmental delay            | Yes | No |
| 2. Family history of permanent childhood hearing loss   | Yes | No |
| 3. NICU stay greater than five days, ECMO, ototoxic medications, loop diuretics, exchange transfusion | Yes | No |
| 4. In utero infections such as CMV, herpes, rubella, syphilis, Toxoplasmosis                          | Yes | No |
| 5. Craniofacial anomalies, especially involving the ear and temporal bone                             | Yes | No |
| 6. Stigmata of syndromes known to cause hearing loss, Eustachian tube dysfunction                     | Yes | No |
| 7. Syndromes associated with hearing loss or progressive or late-onset hearing loss                   | Yes | No |
| 8. Neurodegenerative disorders or sensory motor neuropathies  | Yes | No |
| 9. Postnatal infections associated with sensorineural hearing loss including bacterial meningitis     | Yes | No |
| 10. Head trauma   | Yes | No |
| 11. Chemotherapy  | Yes | No |
| 12. Recurrent or persistent ear infection for at least 3 months                                       | Yes | No |

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Please check the box and sign if there have been no changes to the above answers since the last checkup.

- |   |               |            |
|---|---------------|------------|
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |

Patient Name: \_\_\_\_\_



## Developmental Drawing Sheet

Please use this sheet to allow your child to show us their creativity. This is not only fun for your child, but also allows us to observe fine motor and cognitive skills. Several age groups are listed. Find your child's age and ask them to complete the activities for that age. Remember to allow your child to practice these skills with you at home. Coloring is fun and great for your child's brain development. When you are done, draw a picture on the back of the page.

15 Months- 30 Months Old:

Let your child use your pen and clipboard to have fun and scribble in the space below.

3 & 4 Years Old:

Ask your child to copy the circle and cross pictured below & draw a person.



5 Years Old:

Ask your child to draw a circle and cross, copy the square and triangle pictured below, print some letters and numbers, & draw a person.

CIRCLE:

CROSS:



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Draw us a picture below

# MMRV Vaccine (Measles, Mumps, Rubella, and Varicella): *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See [www.immunize.org/vis](http://www.immunize.org/vis)

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://www.immunize.org/vis)

## 1 Why get vaccinated?

MMRV vaccine can prevent **measles, mumps, rubella, and varicella.**

- **MEASLES (M)** can cause fever, cough, runny nose, and red, watery eyes, commonly followed by a rash that covers the whole body. It can lead to seizures (often associated with fever), ear infections, diarrhea, and pneumonia. Rarely, measles can cause brain damage or death.
- **MUMPS (M)** can cause fever, headache, muscle aches, tiredness, loss of appetite, and swollen and tender salivary glands under the ears. It can lead to deafness, swelling of the brain and/or spinal cord covering, painful swelling of the testicles or ovaries, and, very rarely, death.
- **RUBELLA (R)** can cause fever, sore throat, rash, headache, and eye irritation. It can cause arthritis in up to half of teenage and adult women. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects.
- **VARICELLA (V)**, also called chickenpox, can cause an itchy rash, in addition to fever, tiredness, loss of appetite, and headache. It can lead to skin infections, pneumonia, inflammation of the blood vessels, swelling of the brain and/or spinal cord covering, and infection of the blood, bones, or joints. Some people who get chickenpox get a painful rash called shingles (also known as herpes zoster) years later.

Most people who are vaccinated with MMRV will be protected for life. Vaccines and high rates of vaccination have made these diseases much less common in the United States.

## 2 MMRV vaccine

MMRV vaccine may be given to **children 12 months through 12 years of age**, usually:

- First dose at 12 through 15 months of age
- Second dose at 4 through 6 years of age

MMRV vaccine may be given at the same time as other vaccines. Instead of MMRV, some children might receive separate shots for MMR (measles, mumps, and rubella) and varicella. Your health care provider can give you more information.

## 3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of MMRV, MMR, or varicella vaccine**, or has any **severe, life-threatening allergies.**
- Is **pregnant**, or thinks she might be pregnant.
- Has a **weakened immune system**, or has a **parent, brother, or sister with a history of hereditary or congenital immune system problems.**
- Has ever had a **condition that makes him or her bruise or bleed easily.**
- Has a **history of seizures**, or has a **parent, brother, or sister with a history of seizures.**
- Is **taking, or plans to take salicylates** (such as aspirin).
- Has recently **had a blood transfusion or received other blood products.**
- Has **tuberculosis.**
- Has **gotten any other vaccines in the past 4 weeks.**

In some cases, your health care provider may decide to postpone MMRV vaccination to a future visit, or may recommend that the child receive separate MMR and varicella vaccines instead of MMRV.



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

Your health care provider can give you more information.

## 4 Risks of a vaccine reaction

- Soreness, redness, or rash where the shot is given can happen after MMRV vaccine.
- Fever or swelling of the glands in the cheeks or neck sometimes occur after MMRV vaccine.
- Seizures, often associated with fever, can happen after MMRV vaccine. The risk of seizures is higher after MMRV than after separate MMR and varicella vaccines when given as the first dose of the series in younger children. Your health care provider can advise you about the appropriate vaccines for your child.
- More serious reactions happen rarely. These can include pneumonia, swelling of the brain and/or spinal cord covering, or temporary low platelet count which can cause unusual bleeding or bruising.
- In people with serious immune system problems, this vaccine may cause an infection which may be life-threatening. People with serious immune system problems should not get MMRV vaccine.

It is possible for a vaccinated person to develop a rash. If this happens, it could be related to the varicella component of the vaccine, and the varicella vaccine virus could be spread to an unprotected person. Anyone who gets a rash should stay away from people with a weakened immune system and infants until the rash goes away. Talk with your health care provider to learn more.

Some people who are vaccinated against chickenpox get shingles (herpes zoster) years later. This is much less common after vaccination than after chickenpox disease.

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](http://www.vaers.hhs.gov) or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff 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. Visit the VICP website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation) or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

## 7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines)

Vaccine Information Statement (Interim)  
**MMRV Vaccine**



Office use only

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

Many Vaccine Information Statements are available in Spanish and other languages. See [www.immunize.org/vis](http://www.immunize.org/vis)

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## 1 Why get vaccinated?

DTaP vaccine can help protect your child from diphtheria, tetanus, and pertussis.

- **DIPHTHERIA (D)** can cause breathing problems, paralysis, and heart failure. Before vaccines, diphtheria killed tens of thousands of children every year in the United States.
- **TETANUS (T)** causes painful tightening of the muscles. It can cause “locking” of the jaw so you cannot open your mouth or swallow. About 1 person out of 5 who get tetanus dies.
- **PERTUSSIS (aP)**, also known as Whooping Cough, causes coughing spells so bad that it is hard for infants and children to eat, drink, or breathe. It can cause pneumonia, seizures, brain damage, or death.

Most children who are vaccinated with DTaP will be protected throughout childhood. Many more children would get these diseases if we stopped vaccinating.

## 2 DTaP vaccine

Children should usually get 5 doses of DTaP vaccine, one dose at each of the following ages:

- 2 months
- 4 months
- 6 months
- 15–18 months
- 4–6 years

DTaP may be given at the same time as other vaccines. Also, sometimes a child can receive DTaP together with one or more other vaccines in a single shot.

## 3 Some children should not get DTaP vaccine or should wait

DTaP is only for children younger than 7 years old. DTaP vaccine is not appropriate for everyone—a small number of children should receive a different vaccine that contains only diphtheria and tetanus instead of DTaP.

Tell your health care provider if your child:

- Has had an **allergic reaction after a previous dose of DTaP**, or has any **severe, life-threatening allergies**.
- Has had a **coma or long repeated seizures within 7 days after a dose of DTaP**.
- Has **seizures or another nervous system problem**.
- Has had a condition called **Guillain-Barré Syndrome (GBS)**.
- Has had **severe pain or swelling after a previous dose** of DTaP or DT vaccine.

In some cases, your health care provider may decide to postpone your child’s DTaP vaccination to a future visit.

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

Your health care provider can give you more information.



## 4 Risks of a vaccine reaction

- Redness, soreness, swelling, and tenderness where the shot is given are common after DTaP.
- Fever, fussiness, tiredness, poor appetite, and vomiting sometimes happen 1 to 3 days after DTaP vaccination.
- More serious reactions, such as seizures, non-stop crying for 3 hours or more, or high fever (over 105°F) after DTaP vaccination happen much less often. Rarely, the vaccine is followed by swelling of the entire arm or leg, especially in older children when they receive their fourth or fifth dose.
- Long-term seizures, coma, lowered consciousness, or permanent brain damage happen extremely rarely after DTaP vaccination.

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 child 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 child to the nearest hospital.

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

Serious reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor will usually file this report, or you can do it yourself. Visit [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or call 1-800-822-7967. *VAERS is only for reporting reactions, it does 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. Visit [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation) or call 1-800-338-2382 to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

## 7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines)

Vaccine Information Statement (Interim)  
DTaP (Diphtheria, Tetanus,  
Pertussis) Vaccine



Office use only

# Polio Vaccine:

## What You Need to Know

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Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://www.immunize.org/vis)

### 1 Why get vaccinated?

**Polio vaccine** can prevent **polio**.

Polio (or poliomyelitis) is a disabling and life-threatening disease caused by poliovirus, which can infect a person's spinal cord, leading to paralysis.

Most people infected with poliovirus have no symptoms, and many recover without complications. Some people will experience sore throat, fever, tiredness, nausea, headache, or stomach pain.

A smaller group of people will develop more serious symptoms that affect the brain and spinal cord:

- Paresthesia (feeling of pins and needles in the legs),
- Meningitis (infection of the covering of the spinal cord and/or brain), or
- Paralysis (can't move parts of the body) or weakness in the arms, legs, or both.

Paralysis is the most severe symptom associated with polio because it can lead to permanent disability and death.

Improvements in limb paralysis can occur, but in some people new muscle pain and weakness may develop 15 to 40 years later. This is called post-polio syndrome.

Polio has been eliminated from the United States, but it still occurs in other parts of the world. The best way to protect yourself and keep the United States polio-free is to maintain high immunity (protection) in the population against polio through vaccination.

### 2 Polio vaccine

**Children** should usually get 4 doses of polio vaccine, at 2 months, 4 months, 6–18 months, and 4–6 years of age.

Most **adults** do not need polio vaccine because they were already vaccinated against polio as children. Some adults are at higher risk and should consider polio vaccination, including:

- people traveling to certain parts of the world,
- laboratory workers who might handle poliovirus, and
- health care workers treating patients who could have polio.

Polio vaccine may be given as a stand-alone vaccine, or as part of a combination vaccine (a type of vaccine that combines more than one vaccine together into one shot).

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

### 3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

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

In some cases, your health care provider may decide to postpone polio vaccination to 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 polio vaccine.

Your health care provider can give you more information.

## 4 Risks of a vaccine reaction

- A sore spot with redness, swelling, or pain where the shot is given can happen after polio vaccine.

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.

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