Introduction letter to the parent/guardian

Your child will be entering Cambia Hills Residential Treatment at The Hills Youth and Family Services, which should create a turning point in your child’s life. At The Hills Youth and Family Services, we recognize the potential in all youth and believe that they have the ability to change and become more productive members of society. We are eager to partner with you to provide the best possible care and treatment for your son/daughter. Please feel free to share your concerns and hopes with your son/daughter’s Case Manager. The following overview will provide you information about the program and what to expect. If you have any questions, please contact Toni Jurmu, Admissions Coordinator, at 218-728-7500 ext. 141.

Below is a list of intake forms we need to complete and other forms you may take with you:

- General Consent and Authorization
- Medical Authorization and Immunization
- Essentia General Consent
- Admission Medication Instructions
- Over the Counter Medication Consent
- Medication Release Form
- Health History Questionnaire
- Informed Consent for Treatment
- Visitation Policy
- Admissions form
- Socioeconomic Information
- Woodland Hills Academy Consent Form
- Data Sharing and Client Rights Acknowledgement
- Community Activities Consent
- General Information
- Clothing and Personal Hygiene Guidelines
- Directions
- Client Rights
- MN Provider Notice of Privacy Practices (HIPAA)
- Vaccine Information Sheets

Please bring the following items to your child’s intake:

- Medication: We recommend a ten day supply. Medications need to be labeled with your child’s name and dosing instructions. If you want your child to take any over the counter medications, please supply.
- Insurance Cards: We will need to make copies of any medical insurance, dental, optical, or prescription cards.

Education

Upon admittance, your child will be enrolled in Woodland Hills Academy, which is part of Duluth Public Schools. The education staff will coordinate with the student’s home school district to determine your child’s educational needs. Students receive personal attention and are given many opportunities to excel in their education.

Questions regarding your child’s education may be directed to Woodland Hills Academy at 218-728-7492.

The Case Manager

During your child’s intake to Cambia Hills Residential Treatment you will meet and work with your child’s Case Manager. He/she is responsible for your child’s case management and for working with you to develop treatment plans and transition (discharge) planning. He/she will be your main contact for progress updates and any concerns you have. The Case Manager will also be available to meet with you at all staffings and at any additional meetings jointly scheduled. You may call your child’s Case Manager at 218-728-7500 ext. 130.

Visitation-Mail-Phone Calls

Immediate family members are allowed to visit as arranged with the Case Manager. Other family members may visit with approval. Formal visitation occurs on Sunday afternoons from 1:00 p.m. - 4:00 p.m. or as arranged with the Case Manager. Woodland Hills will make every effort to accommodate special visiting times due to work schedules, transportation schedules, or for other reasonable needs.

Staff will deliver mail daily. Stamps are provided by Cambia Hills for your child to write letters.

Telephone days are twice a week at allotted times or as approved by the Case Manager and phone calls are limited to the names on your child’s approved call list.

If you have any questions please feel free to call at 728-7500 ext. 130. Thank you.
Dear Parent or Guardian:

For over a century, The Hills Youth and Family Services has provided unwavering hope and opportunity for youth, families and communities. Our holistic programs serve the complex array of children’s needs and promote behavioral, mental and chemical health, and physical well-being. At The Hills Youth and Family Services we believe in the potential of every youth we serve and we strive to help each child find his or her own potential.

Your child will participate in one of the residential programs at The Hills Youth and Family Services. We will need your help and participation. Please share your concerns with your child’s case manager once he/she has been admitted and be prepared for an open dialogue on how we can partner with you in the care of your child. The following packet includes admission and consent forms which are needed upon your child’s placement with us, as well as an overview about the program and what to expect.

**REQUIRED FORMS** - Must be completed before admission. Please email to admissions@woodlandhills.org, fax to 218-728-7501, or mail to the address below.

- **Required Forms**
  - Admissions Form for the Parent/Guardian with Parent/Guardian Feedback
  - Visitation/Phone Call Policy and List

- **Required Medical Forms**
  - **Essentia Health General Consent and Authorization** - Required for us to obtain medical services from Essentia Health providers for your child.
  - **The Hills Youth and Family Services General Consent and Authorization** - Required for us to provide medical care to your child from our Wellness Center and, if applicable, provide therapy services.
  - **The Hills Youth and Family Services Medical Provider Access Authorization** - Gives us permission to take your child to a hospital for example, should he or she need urgent or emergency care.
  - Medical Insurance Form
  - Current Medication List
  - Health History Questionnaire

**ADDITIONAL FORMS**

- ISD 709 release form
- Strengths/Difficulties Questionnaire
- Publicity & Community Activities Consent Form
- Data Sharing/Student Right’s Acknowledgement

**GENERAL INFORMATION**

- Over the Counter Medication Information
- General Information
- What to Bring
- Directions
- Client Rights

- Socioeconomic Information (confidential – for funding purposes only)
- Notice of Privacy Practices
- Vaccine information sheets

4321 Allendale Avenue Duluth MN, 55803 – 218-728-7500 (phone) – 218-728-7501 (fax) – admissions@woodlandhills.org
# ADMISSIONS FORM FOR THE PARENT/GUARDIAN

## Child’s Identifying Information

<table>
<thead>
<tr>
<th>Child’s Full Name</th>
<th>Nick Name</th>
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<tbody>
<tr>
<td>Social Security #</td>
<td>Date of Birth</td>
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<tr>
<td>Race and/or Ethnic Origin – Tribal Affiliation</td>
<td>Religion or Church Affiliation</td>
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<tr>
<td>Primary language</td>
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## Parent/Guardian Contact Information

<table>
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<tr>
<th>Parent’s Name (1)</th>
<th>Home Phone</th>
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<tbody>
<tr>
<td>Custodial Parent?</td>
<td>Work Phone</td>
</tr>
<tr>
<td>Parent’s Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td>Cell Phone</td>
</tr>
<tr>
<td>City</td>
<td>State/Zip</td>
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<tr>
<td>Email Address</td>
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</table>

<table>
<thead>
<tr>
<th>Parent’s Name (2)</th>
<th>Home Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custodial Parent?</td>
<td>Work Phone</td>
</tr>
<tr>
<td>Parent’s Date of Birth</td>
<td></td>
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<tr>
<td>Street Address</td>
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<tr>
<td>City</td>
<td>State/Zip</td>
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<td>Email Address</td>
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## Emergency Contact (in the event we can’t reach the parent/guardian)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Child</th>
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<tbody>
<tr>
<td>Home Phone</td>
<td>Work Phone</td>
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<tr>
<td>Cell Phone</td>
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Parent Input

1. What are your goals for your son/daughter’s placement at The Hills Youth and Family Services?
________________________________________________________________
________________________________________________________________

2. What strengths, skills, or positive qualities does your son/daughter possess?
________________________________________________________________
________________________________________________________________

3. What concerns do you have about your son/daughter’s placement at The Hills Youth and Family Service?
________________________________________________________________
________________________________________________________________

4. What is the best time of day and place for the Case Manager to contact you?
________________________________________________________________
________________________________________________________________
Visitation Policy

Client Name: ____________________________________________

Parents have the opportunity to visit their son/daughter every Sunday between the hours of 1:00 and 4:00 pm or as arranged. **Clients can only receive immediate family for visitation and no more than six people per visit.** Any exceptions to this policy need to be approved by your child’s Case Manager in advance. In addition, please don’t bring the following items into the facility during your visit: food, cell phones, or tobacco products. Please indicate below the people you would like to be allowed to visit your son/daughter during his/her placement at Woodland Hills. If the visitor listed is not a parent/guardian/worker, please include their age.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to your son/daughter</th>
<th>Age</th>
<th>Telephone # (if applicable)</th>
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</tbody>
</table>
In order for Essentia Health to treat you, we ask you to sign below indicating your consent to treatment:

A. I give my consent to Essentia Health doctors and healthcare workers to perform exams, treatments, x-rays, lab tests and operations, and to give me medicine that they believe is necessary or helpful to my health.

B. I understand that while I am receiving care, a healthcare worker may accidentally be exposed to my blood or other body fluid. If this rare event occurs, I consent to have my blood tested for blood-borne pathogens, such as Hepatitis B and C, and HIV. I understand that the test results will become part of my medical record and will be released to the exposed healthcare worker and a positive result must be reported to the state by law.

C. I authorize payment from Medicare, Medicaid, insurance and any other funds be paid directly to Essentia Health for my care and treatment. I understand that it is my responsibility to comply with the requirements of my insurance policies.

D. I agree to pay any charges not covered by insurance, government programs (including Medical Assistance), or other funds. I further agree to pay reasonable attorney fees and all costs of collection in the event my account is turned over to an attorney or collection agency. I understand that it is my responsibility, not Essentia Health's, to negotiate for payment of a claim that is disputed by the payer.

E. A copy of the Patient Bill of Rights, information on Healthcare Directives, and information about how to file a complaint has been given to me.

F. I request that payment of authorized Medicare benefits be made on my behalf to Essentia Health for any services furnished me by an Essentia Health provider and/or in an Essentia Health facility. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

G. I request that payment of authorized Medigap (supplemental insurance) benefits be made on my behalf to Essentia Health for any services furnished to me by an Essentia Health provider and/or in an Essentia Health facility. I authorize any holder of medical or other information about me to release to my Medigap carrier any information needed to determine these benefits or benefits for related services.

H. I authorize Essentia Health to utilize my 60 lifetime reserve days as necessary after expiration of regular Medicare Benefits. I understand if reserve benefits are used, there will be co-insurance due, and once used they are permanently reduced by the number of days used.

I. I consent for medical photographs to be made of me (or the person for whom I am legal guardian). I understand that the information may be used in my medical record, and/or for purposes of medical teaching. Refusal to consent to photographs will in no way affect the medical care I will receive.

J. I acknowledge and understand I am responsible for my personal valuables (including money, jewelry, dentures, hearing aides, eyeglasses, etc.) while a patient at Essentia Health. While a patient, I have been encouraged to send all personal items of value home with relatives or friends. I also acknowledge I have been informed of the availability of safekeeping for my personal valuables. I release Essentia Health from any liability for loss by theft or negligence of mine or any hospital employee of my personal valuables.

Essentia Health respects your right to privacy. Under the following conditions your health information will only be released with your consent:

K. I authorize Essentia Health to release my medical records to, and as needed, to discuss my care with my doctors, other healthcare providers, and anyone else Essentia Health either believes to be involved in, or who may participate in my care, treatment, case management and/or discharge planning. This includes source documents (such as x-rays). I authorize Essentia Health to electronically release my protected health information to other healthcare providers involved in my care and treatment and who share electronic medical record systems with Essentia Health. This includes information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, developmental disabilities and genetic testing results.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of a minor  ☐ Court appointed guardian/conservator  ☐ Other: ___________________________ (Please specify relationship to patient)

_____________________________  ____________________________  __________________________
Signature (Patient or Authorized Representative)  Date  Time

Witness (signature by mark must be witnessed)

_____________________________
Patient Name & Medical Record Number OR Patient Label
L. To improve the coordination of my care, I authorize Essentia Health to electronically release my protected health information to other healthcare providers involved in my care and treatment and who participate in local, state, and/or national Health Information Exchanges. This may include information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, developmental disabilities and genetic testing results.

M. I authorize Essentia Health to release my protected health information to insurance companies, government programs, and other parties who are responsible for, or who facilitate, payment of my bill, fraud investigation, care management, or quality improvement. This includes behavioral health and chemical dependency information. Essentia Health may also release my protected health information to suppliers of medical equipment, special transportation, or other health services so they can request payment from my insurance or other payer. I also authorize Essentia Health to release my protected health information to organ procurement organizations to facilitate donations, and to e-Prescribing networks to facilitate prescription management.

N. I authorize Essentia Health to release information from my medical records: as needed by the Federal Food and Drug Administration (FDA) or manufacturers of drugs or medical devices to contact me about defects or recalls; or to emergency service providers involved in my care before and during transport to Essentia Health, for quality improvement.

O. I authorize Essentia Health to release information from my medical records and source data as needed to accrediting organizations and to legally authorized agencies to oversee healthcare activities and to physician specialty boards for board certification/re-certification of physicians.

P. I authorize Essentia Health to release information from my medical and billing records for scientific and health services research to improve patient care and delivery. I may object at any time to release of my protected health information for scientific research.

Q. If I have agreed to participate in Guarantor Billing, I authorize my bill to be combined into one statement that, as applicable, covers my current spouse and minor children with the same mailing address. This statement will be sent to the guarantor listed on my account. The combined billing statement will include patient name, the date of service, the location of service, a brief summary of the services received (including type/name of diagnostic tests) and the amount due. I authorize Essentia Health to discuss billing or payment-related issues with the listed guarantor who provides my name, address, date of birth, and my Essentia Health account number(s) for the dates of service to which this authorization applies, as well as his or her own name and address.

R. I authorize Essentia Health to disclose my presence and religious preference to Essentia Health Chaplains and to clergy of my denomination, and to disclose my presence to foundations that support Essentia Health and its mission. I understand that Essentia Health will ask specific permission before disclosing my presence for behavioral health or chemical dependency services.

S. I agree to the presence of students, observers from other healthcare facilities, healthcare consultants and approved representatives of medical service providers during tests, exams, medical treatments and other services at Essentia Health. I understand that Essentia Health will also seek my oral permission to have non-Essentia Health persons present during any services.

T. I authorize my health insurance plan to release to Essentia Health my protected health information about services I have received from Essentia Health and other care providers unrelated to Essentia Health. Essentia Health may use this information for treatment, payment, operations and case management purposes.

U. When consent is required under applicable state law, I authorize Essentia Health to access my current prescription history of regulated controlled substances in any applicable state databases (such as Minnesota’s RxSentry PMP database).

V. I understand that this authorization ends one (1) year from the date signed except for purposes of payment and research.

W. If this is my first visit to this Essentia Health location, I acknowledge that a copy of the current Notice of Privacy Practices has been provided to me and is available to me via postings in the registration areas and on the website www.essentiahealth.org. I understand that I can ask for a copy of the notice at any time.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of a minor ☐ Court appointed guardian/conservator ☐ Other: _______________________________ (Please specify relationship to patient)

_________________________ / /
Signature (Patient or Authorized Representative) Date

Witness (signature by mark must be witnessed)

GENERAL CONSENT AND AUTHORIZATION

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Essentia Health

CON.016 Org. 7/04; Rev. 7/05, 3/07, 1/08, 11/08, 1/09, 7/09, 01/11, 04/11, 09/11; 3/12; 01/13, 11/14

Caduceus#: 52670 Lawson#: 52670

Original: Medical Record Copy: Patient
Patient Pre-Registration Form

Name: ______________________________________________________________

Date of Birth: ________________________  Gender: Male  Female

Social Security Number: __________________  Email: ______________________

Telephone Number: ____________________  Facility: ______________________

Address: ____________________________________________________________

Primary Care Physician: ________________________________________________

Preferred Language: ____________________  Ethnicity: Hispanic    Non-Hispanic other:

Marital Status: ________________________  Race: ___________________________

Birth City/State_______________________  Mother’s Maiden Name: ______________________

Employer Name/Address: ________________________________________________

Emergency Contact (Name, phone, relationship): ____________________________

Guarantor Information (If different from patient, otherwise indicate same as patient)

Name: ________________________________

Address/Phone: _________________________

Relationship to patient: ___________________  Date of Birth: ________________________

Social Security Number of Guarantor: _________________________________

Name of Insurance: ___________________________________________________

ID #: ____________________________  Group #: ____________________________

Billing address of insurance: ____________________________________________

Name of policy holder (for insurance): ________________________________

Legal Guardian (Name, Address, Phone) __________________________________

______________________________________________________________

Accident or Injury related: Yes  No

If accident or injury related, list date of accident and insurance information for company to bill (Work Comp., Third Party Liability, Motor Vehicle)
GENERAL CONSENT AND AUTHORIZATION

In order for The Hills Youth and Family Services to treat you, please sign below indicating your consent to treatment:

A. I give my consent to The Hills Youth and Family Services mental health practitioners and healthcare workers to perform exams, tests and assessments, provide treatment, administer immunizations, and give me over the counter (see the Over The Counter Medication Information Form at the back of this packet for more information) or prescription medicine that has been prescribed for me that they believe are necessary or helpful to my health.

B. I understand that while I am receiving care, a The Hills Youth and Family Services employee may accidentally be exposed to my blood or other body fluid. If this rare event occurs, I consent to have my blood tested for blood-borne pathogens, such as Hepatitis B and C, and HIV. I understand that the test results will become part of my medical record and will be released to the exposed individual and a positive result must be reported to the state by law.

C. I authorize payment from Medicare, Medicaid, insurance, and any other funds to be paid directly to The Hills Youth and Family Services for my care and treatment. I understand that it is my responsibility to comply with the requirements of my insurance policies.

D. I agree to pay any charges not covered by insurance, government programs (including Medical Assistance), or other funds for healthcare services provided by The Hills Youth and Family Services.

E. A copy of the Patient Bill of Rights, information on Healthcare Directives, and information about how to file a complaint has been given to me.

F. If applicable, I request that payment of authorized Medicare benefits be made on my behalf to The Hills Youth and Family Services for any services furnished me by a The Hills Youth and Family Services provider and/or in a The Hills Youth and Family Services facility. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of a minor ☐ Court appointed guardian/conservator ☐ Other: ____________________________

(Please specify relationship to patient)

Client’s Full Name: ______________________________________

Signature (Patient or Authorized Representative) ____________________________ Date ________________ Time ________________

The Hills Youth and Family Services respects your right to privacy. Under the following conditions your health information will only be released with your consent:

G. I authorize The Hills Youth and Family Services to release my medical records to and, as needed, to discuss my care with my doctors, other healthcare providers, and anyone else The Hills Youth and Family Services either believes to be involved in, or who may participate in my care, treatment, case management, and or/discharge planning. This includes source documents (such as x-rays). I authorize The Hills Youth and Family Services to electronically release my protected health information to other healthcare providers involved in my care and treatment and who share electronic medical record systems with The Hills Youth and Family Services. This includes information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, and developmental disabilities.

Page 1 of 2
H. To improve the coordination of my care, I authorize The Hills Youth and Family Services to electronically release my protected health information to other healthcare providers involved in my care and treatment and who participate in local, state, and/or national Health Information Exchanges. This may include information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, and development disabilities.

I. I authorize The Hills Youth and Family Services to release my protected health information to insurance companies, government programs, and other parties who are responsible for, or who facilitate, payment of my bill, fraud investigation, care management, or quality improvement. This includes behavioral health and chemical dependency information. I also authorize The Hills Youth and Family Services to release my protected health information to e-Prescribing networks to facilitate prescription management.

J. I authorize The Hills Youth and Family Services to release information from my medical records to emergency service providers involved in my care.

K. I authorize The Hills Youth and Family Services to release information from my medical records and source date as needed to accrediting organizations and to legally authorized agencies to oversee healthcare activities and to specialty boards for board certification/recertification of healthcare practitioners.

L. I authorize The Hills Youth and Family Services to discuss bill or payment issues with an adult household member who gives my name, address, date of birth, and either my account number or insurance ID number as well as his or her own name and address.

M. I authorize The Hills Youth and Family Services to disclose my presence and religious preference to The Hills Youth and Family Services chaplains and to clergy of my denomination, and to disclose my presence to foundations that support The Hills Youth and Family Services and its mission. I understand that The Hills Youth and Family Services will ask specific permission before disclosing my presence to behavioral health or chemical dependency services.

N. I agree to the presence of staff, observers from other healthcare facilities, healthcare consultants, and approved representatives of medical service providers during treatment and other services at The Hills Youth and Family Services. I understand that The Hills Youth and Family Services will also seek my oral permission to have non-The Hills Youth and Family Services persons present during any services.

O. I authorize my health insurance plan to release to The Hills Youth and Family Services my protected health information about services I have received from The Hills Youth and Family Services and other care providers unrelated to Woodland Hills. The Hills Youth and Family Services may use this information for treatment, payment, operations, and case management purposes.

P. I understand that this authorization ends (1) year from the date signed except for purposes of payment and research.

Q. If this is the first time I have received medical/behavioral health services from The Hills Youth and Family Services, I acknowledge that a copy of the current Notice of Privacy Practices has been provided to me and is available to me via postings in the registration areas and on the website www.woodlandhills.org. I understand that I can ask for a copy of the notice at any time.

- I understand that I may revoke this permission at any time by notifying The Hills Youth and Family Services in writing. No further release will take place after the date notified.
- I understand that other parties may use or disclose health information received from Woodland Hills.
- I understand that The Hills Youth and Family Services will treat me whether or not I consent to sections H-I and K-N of this document.
- I understand I will receive a copy of this form.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of a minor ☐ Court appointed guardian/conservator ☐ Other: ___________________________ (Please specify relationship to patient)

__________________________ ____________________________ ____________________________
Signature (Patient or Authorized Representative) Date Time
THE HILLS YOUTH AND FAMILY SERVICES MEDICAL PROVIDER ACCESS AND IMMUNIZATION AUTHORIZATION

A. I give The Hills Youth and Family Services authority to determine what sort of medical assistance or treatment is appropriate and circumstances under which medical attention should be sought. This will include, but not be limited to, choosing medical providers to provide for dental, vision, or other medically related services. The parent or guardian will be contacted for consultation or permission to act in situations requiring services outside of the standard practices of The Hills Youth and Family Services. This includes dental care and extraction of teeth upon the recommendation of a dentist. Consent includes release of findings, results, and other information related to these medical and health issues.

B. I authorize The Hills Youth and Family Services to contact my insurance carrier for information such as ID Number, Group Number, effective dates, or any other necessary information to facilitate medical treatment outside The Hills Youth and Family Services facilities.

C. I understand that it is the practice of the The Hills Youth and Family Services medical staff to offer my child a Seasonal Influenza Vaccination, HPV, Hepatitis A, Hepatitis B, Meningococcal, and TDap vaccination, if my child is due for one based on the guidelines of the CDC and Minnesota Department of Health recommendations. The vaccination information sheets and the Recommended Immunizations for Children are included in this packet for your review. Please check the following boxes if you wish your child NOT be vaccinated for one or all of these:

- Seasonal Influenza Vaccination
- TDap (Tetanus, Diphtheria, and Pertussis)
- HPV (Human Papilloma virus)
- Hepatitis A
- Hepatitis B
- Meningococcal

D. This authorization is in effect as long as this child is a resident of The Hills Youth and Family Services or I revoke this consent in writing.

Client’s Full Name: ____________________________________________

__________________________ _________________________________
Parent/Guardian’s Name Parent/Guardian Date of Birth

__________________________ _________________________________
Parent/Guardian’s Signature Today’s Date
MEDICAL INSURANCE INFORMATION

Client’s Name: ___________________________________________ Date of Birth: ________________

Health Insurance Carrier:
Please provide a photocopy of both sides of the insurance card(s).

Primary Insurance Carrier: ________________________________
Group Number: ___________________________ ID#: ___________________________
Policyholder Name: ___________________________ DOB: ___________________________
Policyholder Employer/Group Name: ___________________________________________

Is client covered by another insurance carrier? If yes, please complete the following.
Secondary Insurance Carrier: ________________________________
Group Number: ___________________________ ID#: ___________________________
Policyholder Name: ___________________________ DOB: ___________________________
Policyholder Employer/Group Name: ___________________________________________

Prescription Coverage:
Please provide a photocopy of both sides of the insurance card(s).

Prescription Coverage Carrier: ________________________________
Group Number: ___________________________ ID#: ___________________________
Rx BIN#: ___________________________ PCN#: ___________________________

Dental Insurance Coverage:
Please provide a photocopy of both sides of the insurance card(s).

Primary Insurance Carrier: ________________________________
Group Number: ___________________________ ID#: ___________________________
Policyholder Name: ___________________________ DOB: ___________________________
Policyholder Employer/Group Name: ___________________________________________

Payment Authorization:
I, (Print Name) ___________________________________________,
Authorize and assign payment of medical benefits to The Hills Youth and Family Services. I authorize the release of any
medical or other protected health information necessary to process this claim. I also understand that I am financially
responsible for whatever portion insurance does not cover including but not limited to insurance deductibles, co-payment
amounts, and non-covered services.

Signature: ___________________________________________ Date: ________________

Relationship to Client (Circle One):  Parent  Legal Guardian

4321 Allendale Avenue Duluth MN, 55803 – 218-728-7500 (phone) – 218-728-7501 (fax) – admissions@woodlandhills.org
THE HILLS YOUTH AND FAMILY SERVICES MEDICATION RELEASE FORM

Complete this form if you desire your child to continue any currently prescribed medication or recommended over the counter medication.

I authorize The Hills Youth and Family Services to administer the following to my child:

<table>
<thead>
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<th>NAME OF MEDICATION</th>
<th>DOSAGE</th>
<th>DIRECTIONS/TIMES GIVEN PER DAY</th>
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Child’s First and Last Name: ____________________________________________

This is/these are the medications prescribed before admission to The Hills Youth and Family Services and are to be continued at this time.

I understand the reason for and the possible side effects of this/these medications. I understand that not all over the counter medications will be covered by insurance or provided without charge by The Hills Youth and Family Services (see additional form for over the counter medication provided by The Hills Youth and Family Services). If they are not covered by insurance, the guardian will be notified and given the option to supply the medication.

If I wish to withdraw my consent I understand that I must do so in writing and that the facility’s physician will be consulted to ensure proper discontinuation of the medication is completed.

Parent/Guardian Name: ________________________________________________
Parent/Guardian Signature: ____________________________________________
Date: ________________________________
Please submit this form to your child’s medical provider(s) that prescribed your child’s current medication(s).

**ADMISSION MEDICATION INSTRUCTIONS FROM PRESCRIBING PRACTITIONER**

Student name: ________________________________
Date of birth: ________________________________ Allergies: ________________________________
Practitioner: ________________________________

Regarding current medication orders: In order to ensure the best care and fulfill our licensing requirements, please provide us with your patient’s current medication orders. The following are all items that our licensing now requires to be provided by the prescribing practitioner. In order to be in compliance and yet respect your time, we have tried to simplify this as much as possible. We appreciate your time and patience in this process. Thank you in advance for your cooperation in providing this information.

**Required items:** Instructions about how the medication must be administered; symptoms that the medication will alleviate; symptoms that would warrant consultation a physician; any directions for monitoring medications (i.e. side effect assessments, any labs or other tests); possible side effects to monitor for.

**PLEASE NOTE:** IF THIS IS FAXED THERE ARE TWO SHEETS

Medication order: _____________________________________________________________
Any special instructions: ________________________________________________________
For diagnosis/to target: ________________________________________________________

Medication order: _____________________________________________________________
Any special instructions: ________________________________________________________
For diagnosis/to target: ________________________________________________________

Medication order: _____________________________________________________________
Any special instructions: ________________________________________________________
For diagnosis/to target: ________________________________________________________

Medication order: _____________________________________________________________
Any special instructions: ________________________________________________________
For diagnosis/to target: ________________________________________________________

Medication order: _____________________________________________________________
Any special instructions: ________________________________________________________
For diagnosis/to target: ________________________________________________________
Please submit this form to your child’s medical provider(s) that prescribed your child’s current medication(s).

Please check items, indicating your agreement with the following (or indicate alternative instructions):

☐ Symptoms that would warrant consultation: Will be addressed on an ongoing basis with Woodland Hills medical providers. RN will monitor and schedule sooner than protocol if symptoms warrant.
☐ Or per these instructions: __________________________________________
____________________________________________________________________
____________________________________________________________________

☐ Monitoring: Per Woodland Hills standing orders [Target Behaviors, MOSES, DISCUS].
☐ Or per these instructions: __________________________________________
____________________________________________________________________
____________________________________________________________________

☐ Labs/tests: Per Woodland Hills Standing Order and/or medical provider’s recommendations.
☐ Or per these instructions: __________________________________________
____________________________________________________________________
____________________________________________________________________

☐ Possible side effects: Use standardized, recent Nursing Drug books and/or pharmacist approved Medication Information.
☐ Or per these instructions: __________________________________________
____________________________________________________________________
____________________________________________________________________

Any additional instructions, comments:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Medical practitioner’s signature: ___________________________
Date: ___________________________

Please Note: This form may be confidentially faxed to the Woodland Hills Admission Department at 218-728-7501.
OVER THE COUNTER MEDICATION INFORMATION FORM

A. The Hills Youth and Family Services may administer the following over the counter medications per package instructions or physician recommendation to your child if they should become ill, experience pain, or have other medical concerns during their stay at The Hills Youth and Family Services. Generic forms of medication may be substituted for brand names.

B. If I have questions about why my child may receive a medication or about potential side effects, I can contact the The Hills Youth and Family Services RN at 218-623-6446.

C. The following medications are provided only as needed with consultation of the RN and/or physician:

Pain Relievers:
- Tylenol (acetaminophen)
- Advil (ibuprofen)
- Icy Hot Topical Pain relief
- Orajel (Benzocaie) for tooth/mouth discomfort

Constipation:
- Milk of Magnesia
- Docusate
- Miralax (if recommended by NP)

Heartburn/Upset Stomach:
- Tums
- Pepto Bismol

Allergic Reaction/Allergies:
- Benadryl (allergic reactions)
- Claritin (Loratadine)
- Zyrtec (Cetirizine)
- Nasal Saline (may be used for congestion also)

Cough/Cold Medicine (not we do not use multi-symptom medication):
- Robitussin (guaifenesin only for cough)
- Sudafed PE (phenylephrine only for nasal congestion/runny nose)
- Cough drops

Topical Anti-itch creams:
- Hydrocortisone
- Benadryl cream
- campho phenique

Other medication if needed:
- Athletes foot cream (Lotrim AF or similar)
- Wart Remover (Salicylic acid)
- Ear Wax Softening Drops (only for wax blocking the ear opening upon assessment)
- Gold Bond Medicated Body Powder (menthol and Zinc oxide)
- Foot Powder
- Melatonin (if recommended by NP)
# Health History Questionnaire

Date form completed: ____/____/____

Client's name: ___________________________________________  D.O.B. ____/____/____

Date of last well child check or medical exam: ______________________  Doctor/Clinic: ________________________

Is child under a doctor’s care? Yes ___  No ___  If yes, for what condition? ________________________

Name of physician or clinic: ____________________________

<table>
<thead>
<tr>
<th>Street address</th>
<th>City</th>
<th>State/Zip</th>
<th>Phone</th>
</tr>
</thead>
</table>

Allergies (Explain)

- No Known Allergies
- Latex
- Bee Sting
- Drugs:
- Food:
- Other:

Childhood Health Conditions/Hospitalizations

- Meningitis
- Chicken pox
- Measles (rubeola)
- Strep infections or scarlet fever
- Lactose Intolerance
- Other:

<table>
<thead>
<tr>
<th>Childhood Health Conditions/Hospitalizations</th>
<th>Childhood Health Conditions/Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mumps</td>
<td>Asthma</td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Asthma</td>
</tr>
<tr>
<td>German measles (rubella)</td>
<td>Surgeries</td>
</tr>
<tr>
<td>Frequent ear infections</td>
<td></td>
</tr>
</tbody>
</table>

Reasons and dates for conditions/hospitalizations/surgeries:

- ______________________
- ______________________
- ______________________

Does your child wear glasses/contacts: Yes ____  No ____

Date of last eye exam: ______________________  Doctor: ________________________

Date of last dental exam: ______________________  Doctor: ________________________

Immunizations: Are they up to date: Yes ____  No ____  If no, explain: ______________________

______________________________

______________________________
List any sports or recreation activities that your son/daughter should not participate in due to medical reasons: 

Has your child had or been treated for any of the following?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Anemia</td>
<td>16.</td>
<td>Chronic diarrhea</td>
</tr>
<tr>
<td>2.</td>
<td>Headaches/migraines</td>
<td>17.</td>
<td>Recent weight change</td>
</tr>
<tr>
<td>3.</td>
<td>Seizures/convulsions</td>
<td>18.</td>
<td>Skin changes/rash</td>
</tr>
<tr>
<td>4.</td>
<td>Thyroid disease</td>
<td>19.</td>
<td>Nose bleeds</td>
</tr>
<tr>
<td>5.</td>
<td>Duodenal/gastric or peptic ulcer</td>
<td>20.</td>
<td>Sinus problems</td>
</tr>
<tr>
<td>11.</td>
<td>Lung disease</td>
<td>26.</td>
<td>Liver disease/hepatitis</td>
</tr>
<tr>
<td>12.</td>
<td>Depression</td>
<td>27.</td>
<td>Sexually transmitted disease</td>
</tr>
<tr>
<td>14.</td>
<td>Broken bones</td>
<td>29.</td>
<td>Other:</td>
</tr>
<tr>
<td>15.</td>
<td>Chemical dependency</td>
<td>30.</td>
<td>Other:</td>
</tr>
</tbody>
</table>

Please explain all "yes" answers from above:

Has anyone in your immediate family had any of the following? (If yes, please state the relationship to your child)

- Diabetes:
- Heart attack before age 50:
- High cholesterol or Triglycerides:
- Tuberculosis:
- Allergy or asthma:
- Behavioral or emotional disorder:
- Hepatitis:
- Heart trouble:
- High blood pressure or stroke:
- Kidney disease:
- Cancer:
- Nervous disease:
- Chemical dependency or alcoholism:
- Other:

Additional Medical Concerns or Questions for the Nurse: 

4321 Allendale Avenue Duluth MN, 55803 – 218-728-7500 (phone) – 218-728-7501 (fax) – admissions@woodlandhills.org
INFORMED CONSENT FOR TREATMENT

I give consent for evaluation and treatment to be provided for myself/my child by The Hills Youth and Family Services.

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.

I agree that there may be certain circumstances in which the provision of my child’s mental health services may be via telemedicine. I understand that the video and audio connections used for telemedicine are secure and meet federal, state, and agency privacy standards. I understand that my participation in telemedicine is voluntary.

I understand that I may terminate treatment at any time.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or was a legal guardian appointed by the court, the client’s parents or legal guardian must sign this consent.

____________________________________
Signature of Patient or Parent/Guardian

____________________________________
Date

______________________________
Printed Name

______________________________
Relationship to Patient (if applicable)
Consent for Release and Exchange of Information

Student Name: _____________________________ Date: ______________
Grade: ______ DOB: __________________

Parent Name: ____________________________
Parent Address: ______________________________________________________________________

I authorize:

Duluth Public Schools, ISD 709
Woodland Hills Academy
110 Redwing Street Duluth MN 55803

To release information to: and/or To receive information from:
The Hills Youth and Family Services
4321 Allendale Avenue Duluth MN 55803

The information to be released:
Official School Records (including but not limited to grades and attendance information)
Special Education Records (including related services) Health Record
Teacher, Counselor, Staff Observations Medical Report
Behavioral Health Mental Health
Other (specify): _________________________________________________________________

I understand that this authorization takes effect the day I sign it. It expires on ____________ or no more
than one year from the date of my signature.

• I also understand I may revoke this authorization at any time by notifying the providing organization in
writing, and it will be in effect on the date notified, except to the extent action has already been taken.
• I understand that the information used or disclosed pursuant to this authorization may be subject to re-
disclosure by the recipient and no longer be protected by Federal privacy regulations.
• I understand that by authorizing use or disclosure of information, there will be no conditions placed on
my health care/educational service or payment for my health care/educational service.
• I understand I will receive a copy of this form after I have signed it.
• I understand that in compliance with MN Statue 144.33 and WI Administrative Code HHS117, I may be
required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical
records.

_________________________________________ ____________________
Parent/Guardian Signature Date
Please complete both sides to the best of your ability, thinking about your child's behavior in the past six months.

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the past six months.

Your child's name ................................................................................................................. Male/Female

Date of birth........................................................................................................................

<table>
<thead>
<tr>
<th>Item</th>
<th>Not True</th>
<th>Somewhat True</th>
<th>Certainly True</th>
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<tbody>
<tr>
<td>Considerate of other people's feelings</td>
<td></td>
<td></td>
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<tr>
<td>Restless, overactive, cannot stay still for long</td>
<td></td>
<td></td>
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<tr>
<td>Often complains of headaches, stomach-aches or sickness</td>
<td></td>
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<tr>
<td>Shares readily with other youth, for example CD's, games, food</td>
<td></td>
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<tr>
<td>Often loses temper</td>
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<tr>
<td>Would rather be alone than with other youth</td>
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<tr>
<td>Generally well behaved, usually does what adults request</td>
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<tr>
<td>Many worries or often seems worried</td>
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<tr>
<td>Helpful if someone is hurt, upset or feeling ill</td>
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<tr>
<td>Constantly fidgeting or squirming</td>
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<tr>
<td>Has at least one good friend</td>
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<tr>
<td>Often fights with other youth or bullies them</td>
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<tr>
<td>Often unhappy, depressed or tearful</td>
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<tr>
<td>Generally liked by other youth</td>
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<tr>
<td>Easily distracted, concentration wanders</td>
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<tr>
<td>Nervous in new situations, easily loses confidence</td>
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<tr>
<td>Kind to younger children</td>
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<tr>
<td>Often lies or cheats</td>
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<tr>
<td>Picked on or bullied by other youth</td>
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<tr>
<td>Often offers to help others (parents, teachers, children)</td>
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<tr>
<td>Thinks things out before acting</td>
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<tr>
<td>Steals from home, school or elsewhere</td>
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<tr>
<td>Gets along better with adults than with other youth</td>
<td></td>
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<tr>
<td>Many fears, easily scared</td>
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<tr>
<td>Good attention span, sees chores or homework through to the end</td>
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Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side
Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

- No difficulties
- Yes-minor difficulties
- Yes-definite difficulties
- Yes-severe difficulties

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?
  - Less than a month
  - 1-5 months
  - 6-12 months
  - Over a year

- Do the difficulties upset or distress your child?
  - Not at all
  - Only a little
  - A medium amount
  - A great deal

- Do the difficulties interfere with your child's everyday life in the following areas?
  - HOME LIFE
  - FRIENDSHIPS
  - CLASSROOM LEARNING
  - LEISURE ACTIVITIES

- Do the difficulties put a burden on you or the family as a whole?
  - Not at all
  - Only a little
  - A medium amount
  - A great deal

Signature ................................................... ........................... . Date ....................................... .

Thank you very much for your help

Robert Goodman, 2005
PUBLICITY AND COMMUNITY ACTIVITIES CONSENT FORM

Client’s Name: ____________________________________________

The Hills Youth and Family Services participates in public relations activities and develops promotional materials that help us tell our story to the community and donors. The story and/or photograph of a The Hills Youth and Family Services client is a powerful way to explain how The Hills Youth and Family Services helps and empowers youth to reach their potential. Involvement with public relations activities include, but are not limited to, public speaking as well as interviews and photographs of clients participating in an agency activity.

We also offer various opportunities for youth to connect with the community while realizing their own strengths. Such activities include, but are not limited to, social theatre productions, Youth Day at the Capitol, Friday Night Hoops, on-campus talent show, poetry slams, involvement with agency events (on and off campus), and 4H competition at county and state fairs.

At times, certain activities, photos, and/or written/verbal statements by students may be considered for the agency’s website, promotional materials (printed or video), or media coverage. Clients may only participate in the aforementioned opportunities if their parent/guardian has given the written consent below. The client always has the choice to participate or not. All attempts will be made to show the youth in a positive, productive manner. We adhere to the confidentiality of students and as such, first names are only used in publicity/community education/media activities.

By signing below, you are giving The Hills Youth and Family Services and your child the consent to participate in publicity/community/media activities deemed appropriate by The Hills Youth and Family Services.

☐ I give consent for my son/daughter to participate in the publicity opportunities and community activities as noted above.

This consent is valid while the client is involved with a The Hills Youth and Family Services program.

____________________________
Parent/Guardian Signature

__________________________
Date
DATA SHARING AND STUDENT RIGHTS ACKNOWLEDGEMENT FORM

Client’s Name: ______________________________

Consent to Participate in Outcome Data Sharing

It is the policy of The Hills Youth and Family Services to evaluate its programs and services continuously in order to provide the most effective care for youth placed with us. Use of administrative data including aggregate referral and program data obtained on clients at intake and during placement is considered normal business practice and follows all licensing, accreditation, and ethical guidelines as well as data privacy. Beyond collecting the aforementioned data, your participation and consent is requested for additional research activities, which further our ability to assess program effectiveness and helps us better serve our clients. These additional research activities include, but are not limited to, collecting data from the appropriate government or placing agencies about offenses and placements incurred following placement at The Hills Youth and Family Services and general information on the child’s progress after leaving The Hills Youth and Family Services. All information collected is treated as private. This will be assured through the use of identification numbers and reporting of summary results only (names are not used). The information collected is used to improve outcomes, complete funding report requirements and advocate for services for children and families.

I give consent to my son’s/daughter’s/ward’s statistical data to be used for these additional research purposes:

________________________________________________________________________

Parent/Guardian Signature __________________________ Date __________

Client Rights Acknowledgement

A part of this intake packet is a three page document called Client Rights. These rights are basic to quality childcare and cannot be altered or suspended by staff. Clients and parents/guardians should be acquainted with what to expect from the staff and program at The Hills Youth and Family Services. Please call the Admissions Coordinator with any questions, at 218-728-7500 x.141.

I have been given a copy of the Client Rights, and I have had the opportunity to ask questions regarding any item(s) I did not understand.

________________________________________________________________________

Parent/Guardian Signature __________________________ Date __________
Socioeconomic Information

Due to funding guidelines, we are occasionally asked to report in general the following information. All data collected will remain confidential and client names are not used in the reporting process. We apologize for any intrusion and thank you for assisting us.

1. **Number of people in youth’s family/household:** ____

2. **Youth lives with:**
   - Both parents ____
   - Mother only ____
   - Father only ____
   - Mother & stepfather ____
   - Father & stepmother ____
   - Grandparent ____
   - Foster parent ____
   - Other ____

3. **What will the total family/household income for all members be at the end of the year?** Please circle the income range below that corresponds with the number of people living in your household.

   For example, if there are three people living in your home and the total income for all members is $25,000, you would go to the line that starts with number in household: 3, move right, and circle the income box ranging “between $15,900-26,500.”

   The following are examples of sources of income which should be included in the totals:
   - Employment/wages/tips
   - Self-employment
   - Rental property income
   - Unemployment compensation
   - Social security/disability
   - Pensions and severance
   - Retirement
   - Public assistance/AFDC
   - Child support/alimony

<table>
<thead>
<tr>
<th>No. of People in Household</th>
<th>Total Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less than</td>
</tr>
<tr>
<td>1</td>
<td>$12,350</td>
</tr>
<tr>
<td>2</td>
<td>$14,100</td>
</tr>
<tr>
<td>3</td>
<td>$15,900</td>
</tr>
<tr>
<td>4</td>
<td>$17,650</td>
</tr>
<tr>
<td>5</td>
<td>$19,050</td>
</tr>
<tr>
<td>6</td>
<td>$20,450</td>
</tr>
<tr>
<td>7</td>
<td>$21,900</td>
</tr>
<tr>
<td>8</td>
<td>$23,300</td>
</tr>
</tbody>
</table>
General Information

Clothing and Personal Hygiene
Clients are allowed to have their own clothing and hygiene products. Please see the attached list of suggested clothing. Keep in mind the youth at The Hills Youth and Family Services are kept very active, are involved in some kind of work, and spend time outside. Clients will do their own laundry on a weekly basis.

Medical
Each client meets with the nurse (RN) for a physical exam upon being admitted. The nurse is also available if medical issues occur during your child’s stay. Completing the medical forms (under the “required forms”) is critical to receive medical services. Please make sure your child brings at least a two week supply of any prescribed medication. We will also need a copy of both sides of his/her medical insurance card. Please include the birth date of the insurer (or parent/guardian if the student is uninsured). This is required by the Duluth medical, dental, and ophthalmology clinics, as well as all pharmacies in order to register your child for these services. Questions regarding your child’s medical care may be directed to The Hills Youth and Family Services Wellness Center at 218-728-7366, Monday through Friday.

There may be times when your child needs care from medical professionals other than The Hills Youth and Family Services providers. In this event, your child may be transported to an Essentia Health facility to receive medical care. If your child requires laboratory work, the specimen will be processed by an Essentia Health laboratory. Enclosed is an Essentia General Consent form. We ask you to sign this form so that if a The Hills Youth and Family Services Provider determines that it is appropriate to refer your child to an Essentia Health facility, and/or to the lab for treatment, you have given your consent for the provision of that medical care. Questions regarding Essentia Health’s General Consent Form may be directed to Essentia Health’s Supervisor of Registration at 218-786-1221.

Education
Upon admittance, your child will be enrolled at Woodland Hills Academy, which is part of Duluth Public Schools, ISD 709. The education staff will coordinate with your child’s home school district to determine your child’s education stats and needs. Students receive personal attention and are given many opportunities to excel in their education. Questions regarding your child’s education may be directed to Woodland Hills Academy at 218-728-7492.

Phone calls and visits
Contact with family is a very important part of each child’s placement at The Hills Youth and Family Services. Clients are allowed two phone calls per week to immediate family only. Exceptions can be made through the child’s case manager after intake. Visitation is every Sunday between the hours of 1:00 p.m. and 4:00 p.m. or as arranged. Please see the Visitation Guidelines for additional instructions.
**Visit Guidelines**

1. Visits are restricted to immediate family only, unless the youth’s Case Manager and/or placing worker make an exception. Visitation is every Sunday between the hours of 1:00 and 4:00 pm or as arranged. Other times can be arranged as well – please ask your child’s Case Manager.

2. No unauthorized visitors will be allowed on The Hills Youth and Family Services campuses. All visitors must be pre-approved and added to the client’s visitor list by his/her Case Manager.

3. All items brought in for the client will be inventoried before they are given to the client.

4. Anything that is considered inappropriate will be sent home with the visitors that day. To avoid any problems, families should call and talk to the Case Manager about what items are allowed.

5. Cell phones are not allowed.

6. Food is not allowed.

7. Giving money to clients is not allowed. All money will be sent home.

8. Visitors are not to consume alcohol or illegal drugs before or during their visit. Visitors who are suspected being under the influence of drugs or alcohol will be asked to leave The Hills Youth and Family Services campus immediately.

9. The Hills Youth and Family Services have tobacco-free campuses. Visitors may not use tobacco products at any time on the property or in the building.

10. For security reasons, no weapons are allowed on campus (i.e. firearms, knives, etc.).

**The Case Manager**

Soon after your child’s placement at The Hills Youth and Family Services, you will be contacted by your child’s Case Manager. He/She is responsible for all the services your child will receive and will work with you to develop a treatment plan and transition plan. He/She will be your main contact for progress updates and any concerns you have. The Case Manager will also be available to meet with you monthly during Sunday visitation and at staffings. **You may call your child’s Case Manager at 218-728-7500 or 800-644-4557.**

**Additional Opportunities**

Youth in our care are kept busy with a variety of activities from daily treatment group meetings to school. Each group participates in service-learning activities, such as volunteering at nursing homes. On campus, youth have the opportunity to participate in the animal husbandry program featuring llamas, pygmy goats, chickens, rabbits, and sheep. Gardening, recreation, sports, cultural programming, and after-school enrichment are also available. Additional recreational activities include: low ropes course, field trips, camping/hiking trips, fishing, snowshoeing, 4-H, and others. Spiritual exploration is also offered on a voluntary basis.
CLOTHING AND PERSONAL HYGENE GUIDELINES

<table>
<thead>
<tr>
<th>Personal and Hygiene Items</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Soap</td>
<td>Shampoo</td>
</tr>
<tr>
<td></td>
<td>Toothbrush and Paste</td>
</tr>
<tr>
<td></td>
<td>Deodorant</td>
</tr>
<tr>
<td></td>
<td>Laundry bag</td>
</tr>
<tr>
<td></td>
<td>Brush/comb</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommended Clothing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeans/pants</td>
<td>5</td>
</tr>
<tr>
<td>Shirts</td>
<td>7 (short and long-sleeved)</td>
</tr>
<tr>
<td>Socks</td>
<td>9 pairs</td>
</tr>
<tr>
<td>Underwear</td>
<td>8</td>
</tr>
<tr>
<td>Underclothing</td>
<td>2 bras; 2 sport bras</td>
</tr>
<tr>
<td>Shoes</td>
<td>2 pairs (tennis shoes preferably)</td>
</tr>
<tr>
<td>Sleepwear</td>
<td>1 or 2 sets (sweats, shorts, etc.)</td>
</tr>
<tr>
<td>Swimwear</td>
<td>1</td>
</tr>
<tr>
<td>Shorts</td>
<td>4</td>
</tr>
<tr>
<td>Dress shirt</td>
<td>1</td>
</tr>
<tr>
<td>Dress pants</td>
<td>1</td>
</tr>
<tr>
<td>Dress shoes</td>
<td>1</td>
</tr>
<tr>
<td>Bathrobe</td>
<td>1</td>
</tr>
<tr>
<td>Shower shoes</td>
<td>1</td>
</tr>
<tr>
<td>Slippers</td>
<td>1</td>
</tr>
<tr>
<td>Belt</td>
<td>1</td>
</tr>
<tr>
<td>Sweat pants</td>
<td>1</td>
</tr>
<tr>
<td>Sweat shirts:</td>
<td>2</td>
</tr>
<tr>
<td>Gym shorts</td>
<td>1</td>
</tr>
</tbody>
</table>

**Note:** Clients should not bring expensive clothing, jewelry, etc. The Hills is not responsible for items that are lost or stolen.

<table>
<thead>
<tr>
<th>Seasonal clothing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jacket: Winter coat, spring/fall jacket</td>
<td></td>
</tr>
<tr>
<td>Winter boots</td>
<td></td>
</tr>
<tr>
<td>Gloves/mittens</td>
<td></td>
</tr>
<tr>
<td>Winter hat</td>
<td></td>
</tr>
<tr>
<td>Thermal underwear</td>
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</tbody>
</table>
DIRECTIONS TO THE HILLS YOUTH AND FAMILY SERVICES SITES

To The Hills Youth and Family Services Main Campus: 4321 Allendale Avenue Duluth MN 55803 218-728-7500

From Minneapolis-St. Paul
Take I-35 North to Duluth. Exit on 21st Avenue East (Please note to not turn off on 21st Avenue West). Go up 21st Avenue East for about seven blocks to Woodland Avenue, going through several stoplights. Stay in the right hand lane and turn right on Woodland Avenue and go about four miles. Go through the second stop sign (with a Woodland Market on right) and go one block further on Woodland Avenue. Turn left on West Chisholm Street (in front of St. John’s School and Church) and then the next right on St. John’s Avenue. The Hills Youth and Family Services is the third building past the Church - the Church being the first, the rectory second, and in the pines is The Hills Youth and Family Services.

From Eveleth-Virginia via Hwy 53
Go south on Highway 53. Turn left on Arrowhead Road and continue for about eight miles. Turn left on Woodland Avenue and continue for about three miles. Go through the second stop sign (with a Woodland Market on the right) and go one block further on Woodland Avenue. Turn left in front of St. John’s School and Church and then right on St. John’s Avenue. The Hills Youth and Family Services is the third building past the Church - with the Church being the first, the rectory second, and in the pines is The Hills Youth and Family Services.

From Itasca, Beltrami, Polk County areas via Hwy 2
Take Highway 2 East and then go onto Highway 194 until you reach Highway 53 South. Then follow the same directions as from Eveleth-Virginia above.

From Two Harbors
Take Highway 61 onto London Road. Turn right on 21st Avenue East and go for about seven blocks, going through several stoplights. Stay in the right hand lane and turn right on Woodland Avenue, continuing for about four miles. Go to the second stop sign (with a Woodland Market on the right.) Go one block further on Woodland Avenue. Turn left in front of St. John’s School and Church then turn right on St. John’s Avenue. The Hills Youth and Family Services is the third building past the Church – the Church being the first, the rectory second, and in the pines is The Hills Youth and Family Services.

From Wisconsin
Take the Bong or Blatnik Bridge to I-35 North. Then follow the same directions as from Minneapolis-St. Paul above.

From Michigan
Take Highway 2 West to Superior, WI. Take the Blatnik Bridge to I-35 North. Then follow the same directions as from Minneapolis-St. Paul above.

To Woodland Hills Academy: 110 West Redwing Street Duluth MN 55803 218-728-7418

Follow the same directions as listed above, except once on Woodland Avenue, take a left on West Redwing which is before the second stop sign. Park along the side of the Academy (parallel to West Redwing), inside the fenced area.

To Community Transition House: 4210 West St. James Avenue Duluth MN 55803 218-724-5534

Follow the same directions as listed above up to turning left on West Chisholm Street. Once you’ve turned left, just after St. John’s School and Church you will come to a V. Follow the road to the left, which is West St. James Avenue. The CTP house will be on your right at 4210 West St. James Avenue.
Client Rights

The following policy establishes Client Rights at Cambia Hills. These rights are basic to quality childcare and cannot be altered or suspended by staff. Clients and parents/guardians should be acquainted with what to expect from the staff and program at Cambia Hills.

1. **EQUAL TREATMENT**
   
   **Right:** Clients have the right not to be discriminated against because of age, race, gender, language, sexual orientation, national origin, religion, or physical or other disabilities.

   **Discussion:** The law requires that all citizens be treated equally and not discriminated against because of their status. This does not mean that programmatic decisions cannot be based on the particular needs of the individual.

2. **RELIGIOUS FREEDOM**
   
   **Right:** Clients have the right to participate in religious activities of their choice, subject to the availability of such activities. Cambia Hills shall not compel clients to participate in any religious activity.

   **Discussion:** Cambia Hills will make a reasonable effort to provide various guest ministers, priests and other religious leaders to attend to the clients.

3. **PERSONAL POSSESSIONS**
   
   **Right:** Clients have the right to keep and use personal possessions so long as these possessions do not endanger the safety of staff and clients, disrupt programs and activities, encourage deviant values, or appeal to the vulnerability of clients (i.e. weapons and drugs). Personal items are allowed only as defined by the Inventory Intake List.

   **Discussion:** Electronics such as: tablets, cellphones, televisions, and iPods are not allowed. Bicycles, jewelry, musical instruments and other large, expensive, or potentially disruptive items may be restricted based on considerations of facility safety or order. Upon intake all personal items will be searched to insure safety and security.

4. **CONTROL OF CONTRABAND/SEARCHES**
   
   **Right:** During searches the privacy rights of clients are maintained within program guidelines.

   **Discussion:** If contraband is suspected of entering the facility, it is Cambia Hills’ policy to conduct searches of clients and program areas.

5. **MAIL AND TELEPHONE**
   
   **Right:** Clients have the right to correspond freely through the mail. Staff may not read incoming or outgoing mail, but may open mail in the client’s presence to inspect it for contraband. (This includes packages and other bulk items received by the client.)

   **Exception:** If mail is received from a correctional facility, the client and staff will review the mail together. This mutual review will occur as the mail may put the client in a vulnerable position by people that don’t have their best interest at heart.

   **Discussion:** Staff will deliver mail daily. Clients will be provided access to a telephone as described in the Cambia Hills policy and procedure manual on telephone use. Client telephone days are twice a week at allotted times or as approved by the Case Manager.
6. **ACCESS TO ATTORNEYS**
   **Right:** Clients have the right to confer with an attorney in private.
   **Discussion:** It is permissible to require visitors who assert that they are attorneys to produce some evidence of the fact, such as a State Bar Membership Card.

7. **ACCESS TO COURTS**
   **Right:** Clients have the right to request a court review.
   **Discussion:** Clients may request a court review from their referring agent.

8. **FREEDOM FROM PUBLIC DISCLOSURE OR REVIEW**
   **Right:** Clients shall not be required to make public statements of gratitude to the program or be required to perform or appear at public gatherings. Also, unless a client and his/her parents (or legal guardians) give their written consent, Cambia Hills shall not publicly use reports or pictures in which the client can be identified.
   **Discussion:** On occasion, the media and/or Cambia Hills seek to highlight significant events that occur in the lives of our clients. Clients may only participate in these media or public speaking opportunities if their parent/guardian has given consent. The client always has the choice to participate.

9. **CONFIDENTIALITY OF RECORDS**
   **Right:** Clients have the right to expect that their records will not be released to anyone other than: Cambia Hills treatment staff, to include contracted professionals; referring agents; the client’s attorney; and parents.
   **Discussion:** Confidentiality of records is critical. Any information, which could, directly or indirectly, identify an individual as a Cambia Hills client, should be disclosed only to authorized persons or agencies. Cambia Hills’ staff are expected to follow the Minnesota Data Privacy Act and HIPAA regulations.

10. **MEDICAL AND DENTAL CARE**
    **Right:** Clients have the right to basic and necessary medical and dental care, both routine and emergency.
    **Discussion:** A RN is on site five days a week to provide sick call. Emergency care will be provided by Essentia Health Care Systems. Dental care is provided on an as-needed basis. When the nurse is not available, medical care is provided at Essentia Health, West Duluth or the Emergency Room/ Urgent Care at Essentia Health Care Systems. After business hours, medical concerns are addressed by Cambia Hills’ RN. If the RN is unavailable, services are provided by Essentia Health Nurse online, Urgent Care or the Emergency Room.

11. **PROTECTION FROM PHYSICAL AND PSYCHOLOGICAL HARM**
    **Right:** Clients have the right to be protected from physical and psychological harm. They have the right to adequate food, clothing and shelter, and shall not be deprived of these in the interest of treatment or discipline. Clients shall not be administered tranquilizers and other drugs in the interest of treatment, discipline or order. Repetitive, purposeless, degrading work is prohibited. Clients have the right to be free from abuse, neglect, inhumane treatment and sexual exploitation.
    **Discussion:** Every Cambia Hills staff member has an affirmative obligation to take every reasonable precaution to protect youth from harm. This includes proper supervision, adhering to safety procedures, following health precautions, abiding by licensing standards, and accreditation standards.
12. VISITORS

Right: Clients have the right to receive visitors, limited only by considerations of facility security and order. Clients have a corresponding right to refuse to receive visitors. They have a right to reasonable communication and visitation with adults outside the facility (which may include a parent, extended family member, sibling, a legal guardian, a case worker, an attorney, a therapist, a physician, a religious advisor, or a case manager in accordance with their visitation plan).

Discussion: Cambia Hills may place reasonable restrictions on the number of visitors and time and place of visits as necessary to ensure the safe and orderly operation of the program. Limitations on the right to receive visitors shall not be imposed for disciplinary reasons. Visitors who are disorderly, intoxicated or create disturbances may be prohibited from visiting or asked to leave the premises.

13. REASONABLE OBSERVANCE OF CULTURAL AND ETNICT PRACTICE

Right: Clients have the right to reasonable participation and observance of cultural and ethnic practices.

Discussion: Cambia Hills will make reasonable effort to provide cultural activities to clients and allow client participation in cultural/ethnic activities in the community.

14. PUBLIC EDUCATION

Right: Clients have the right to an education.

Discussion: Cambia Hills partners with ISD #709 to provide educational services to Cambia Hills’ youth. When appropriate, clients may attend school in the Duluth community. This is determined by education and treatment staff in conjunction with referring agents and parents/guardians.

15. HEALTHY ENVIRONMENT

Right: Clients have the right to a healthy environment based on respect.

Discussion: Cambia Hills’ clients have the right to positive and proactive adult guidance, support and supervision. They have the right to courteous and respectful treatment. They have the right to be free from restraint or seclusion except when they are in imminent danger to hurt self or others. Clients also have the right to a reasonable degree of privacy as allowed by the facility. They have the right to daily showering and the use of culturally appropriate hygiene products. They have the right to nutritious and sufficient meals and sufficient clothing and housing. They have the right to live in clean, safe surroundings.

16. TREATMENT PLANNING

Right: Clients have the right to participate in the development of their treatment, case or educational plans.

Discussion: Clients are involved in the development of their treatment plans, case plans and educational plans. Parents/guardians and referring agents are also involved in these plans.

17. GRIEVANCE PROCEDURE (CLIENT)

Right: Cambia Hills’ clients have the right to a grievance plan.

If a client has a complaint, suggestion, or wants to express a concern about any aspect of his/her care during their stay in the facility, he/she will put the issue of grievance in writing. Staff will not attempt to influence a client’s statements about the facility in the grievance or during the investigation resulting from the grievance. Grievance forms will be provided to the client who wants to file a grievance. Clients can turn the grievance in to staff or place it in a locked box located throughout the buildings. Clients can expect a hearing and a response within five business
days. The Program Director will hear the issue of grievance, unless he or she is the one being grieved upon or the client appeals the findings of the grievance. In those cases, the Regulatory Compliance Director will be the hearing officer. If the issue is not resolved, then the CEO will hear the issue. If the issue is not satisfactorily resolved at this level, the client may contact their referring for further recourse.

18. GRIEVANCE PROCEDURE (PARENT/GUARDIAN)
Right: Parents or guardians of clients have a right to a grievance procedure.

Grievance Procedure: If a parent/guardian or legal representative of a client at Cambia Hills would like to make a formal complaint or suggestion, or express a concern about a client’s care, they may file a grievance. The grievance should be put in writing and addressed to the Program Director. The Program Director then investigates the grievance and respond to the party that filed it within five working days. If the issue is not resolved to the satisfaction of the parent/guardian or legal representative, the decision may be appealed to the Regulatory Compliance Director or the CEO. He/she would conduct their own investigation and results of that investigation would be given to the concerned party within five working days.

19. FREEDOM FROM SEXUAL ABUSE AND SEXUAL HARASSMENT
Woodland Hills has zero tolerance for sexual abuse and sexual harassment.

Right: Clients have the right to be free from sexual abuse and sexual harassment from staff and other clients. Clients have the right to anonymously report sexual abuse or sexual harassment. Clients have the right to follow-up services if they are a victim of sexual abuse.

Discussion: If a client believes he/she has been a victim of sexual harassment or sexual abuse, he/she can report it in the following ways:

a. Fill out a grievance form;
   
   Note: Grievance forms can be handed in to staff or anonymously placed in locked boxes found on the 2nd and 3rd floor of the main campus building and outside the Falcon, Cougar, or Laker departments.

b. Call 911 (sexual abuse only);

c. Call The Hills Hotline – 218-728-7500 ext: 333; or

d. Report to staff.

Any report of sexual harassment or abuse will be investigated at the direction of the Regulatory Compliance Director or CEO. There will be no retaliation towards any client or family member who reports sexual harassment or sexual abuse.

Woodland Hills works with PAVSA (Program for Aid to Victims of Sexual Assault), a local nonprofit rape crisis center that helps survivors cope with the aftermath of sexual violence. Should a client wish to speak with someone from PAVSA, Woodland Hills can help facilitate communication. For instance, a client will be allowed to privately meet with a PAVSA representative on campus. Should a client wish to call PAVSA, they will be allowed to do so without other clients present however, a Woodland Hills staff member will need to be present in the room to assure safety of the client. Clients should be aware that PAVSA employees are Mandatory Reporters, meaning that they are required by law to report sexual abuse. PAVSA has a 24-hour crisis line that can be reached at 218-726-1931 or they have an office hours phone at 218-726-1442.
20. **OFFICE OF THE OMBUDSMAN**

If any client, parent, guardian, staff, referring agency or other concerned person believes that a client's rights have been violated, have been subjected to any physical or sexual abuse or acts of neglect, said party/ies may contact the Ombudsman of mental health and lodge a complaint. The complaint must be in writing and signed. The address for the Office of the Ombudsman will be posted in a conspicuous place.
This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

To protect your privacy while we handle your health information, The Hills Youth and Family Services follows applicable laws, rules, and procedures. We are required by law to provide you with this Notice of Privacy Practices (“Notice”). This Notice tells you about the ways in which The Hills Youth and Family Services may use and disclose (share) health information about you. We also describe your rights to the health information we keep about you, and describe our obligations regarding the use and disclosure of your health information.

“Health Information” means any information, whether oral, electronic, or paper, which is created or received by The Hills Youth and Family Services and is related to your health care or payment for the provision of medical services. We understand that health information about you and your health care is personal. We are committed to protecting health information about you. The information documenting the care and services you receive from The Hills Youth and Family Services is contained in a medical record, which is the physical property of The Hills Youth and Family Services. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. Typically, your medical record contains your demographic information (such as how we can reach you and your social security number), and other information such as symptoms, diagnoses, treatments, care plans, and other related information.

This Notice applies to all of the records of your care that we maintain, whether made by our staff (such as nurses, therapist, and health care providers contracted to provide services to The Hills Youth and Family Services), support staff, volunteers, or by your personal doctor. Other health care providers may have different policies and notices regarding use and disclosure of your health information created in his or her office or clinic.

This Notice describes The Hills Youth and Family Services’ practices and that of all its employees, staff, and contractors.

Federal and State Laws
Health information may be protected by both federal and state laws and regulations. The Hills Youth and Family Services is required to follow both sets of rules. Sometimes these rules are different. In those cases, The Hills Youth and Family Services must follow the rules that provide greater protection of health information and grant our patients greater rights. Where a state law is more stringent, we have listed that in this Notice.

Uses and Disclosures Without Your Express Permission
We may only use or disclose your health information with your written permission except as described in this Notice or specifically required or permitted by law. If you give written permission, you have the right to withdraw your permission for future uses and disclosures by notifying The Hills Youth and Family Services in writing. A new form to revoke your
permission is available by contacting The Hills Youth and Family Services Compliance Officer at (218) 728-7500. Your permission will end upon receipt of and approval of the signed form.

To provide you with care, we will need to use and disclose your health information. When we use and disclose your health information, we follow the law and take steps to protect your information. We may use and disclose your health information without your prior, express permission as follows:

**Treatment, Payment, and Health Care Operations:** We may use and disclose your health information for:

- Treatment (for the provision, coordination, and management of care, includes sharing information with non-The Hills Youth and Family Services providers who are involved in your care);
- Payment (such as providing bills, service dates, symptoms, and diagnosis to you and your insurance company); and
- Our health care operations. Such activities are necessary for us to provide you with services and manage our organization. Examples of such activities include, but are not limited to: quality improvement activities throughout The Hills Youth and Family Services, evaluating our staff, conducting training activities, obtaining legal and accounting services, conducting audits, business planning, and other management activities.

We may disclose your health information to a non-The Hills Youth and Family Services provider or entity so that they can provide you with treatment and for continuity of care. For example, you may need primary care services from a local physician and we will share your information to make such arrangements. We may also disclose your information to non-The Hills Youth and Family Services providers or entities for them to obtain payment for services provided.

We arrange to provide some services through contracts with business associates. On occasion, we may disclose your health information to business associates acting on our behalf so they can perform the services that we have asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information. Business associates are also required by Federal law to safeguard your health information.

Minnesota law generally requires patient consent (obtained at the time of admission) for disclosures of health information for treatment, payment and health care operations purposes, unless consent is not possible due to a medical emergency.

**Appointment Reminders and Treatment Alternatives:** At times we may access your health information to set up or remind you about future appointments or provide information about treatment and health-related benefits or services that may be of interest to you.

**Facility Directory/Patient Census:** Unless you instruct us not to, we may include your name, location in a facility, a health condition (in general terms, such as “good”, “fair”), and religious affiliation (should you choose to provide one) in a current patient list. This information is maintained for The Hills Youth and Family Services’ personnel to assist family members, staff, and others in locating you while you are at a The Hills Youth and Family Services facility. This information (with the exception of religious affiliation) may be provided to people who ask for you by name. This information (including religious affiliation) may be provided to members of the clergy. If you do not wish to have The Hills Youth and Family Services disclose this information, please inform the person assisting you with registration or admission.
**Relatives, Close Friends, and Others Involved in Your Care:** Healthcare professionals, using their best judgment, may disclose to a family member, close personal friend, or any other person you identify, health information relevant to that person’s involvement in your care or payment related to your care. If family members or friends are present while care is being provided, The Hills Youth and Family Services will assume you agree to have, unless you instruct us not to, your companions hear the discussion. If you do not want The Hills Youth and Family Services to disclose your health information to your family members or others who are involved with your care or handling your bills, please inform the person assisting you during registration or admission.

**Disaster Relief:** Unless you instruct us not to, in the event of a declared disaster, we may disclose your name and location to a public or private entity authorized by law or by its charter to assist in disaster relief efforts (e.g., the Red Cross).

**Fundraising:** We may contact you about supporting our fundraising efforts, programs, and events to support our mission. We may use certain information (name, address, email address, telephone number, dates of service, age, and gender) to contact you in the future to raise money for The Hills Youth and Family Services. We do not sell or rent patient names or contact information to organizations. If you do not want us to contact you for fundraising efforts, you must notify The Hills Youth and Family Services in writing.

**Record Locator Service (may also be known as HIE – Health Insurance Exchange):** In the event of a medical emergency, we may share your demographic information (name, address, date of birth, gender, and location of your health record) with a medical record locator service. This information will help caregivers identify where you have a health record(s) and will assist caregivers to make better decisions about your treatment. For example, if you are admitted to a hospital on an emergency basis and cannot provide important information about your health condition, this service will allow us to make your health information from other participants available to those who need it to treat you at the hospital. When it is needed, ready access to your health information means better care for you.

If you do not want to be included in the record locator service, you may opt-out by completing a written opt-out form. Your opt-out decision will remain in effect until you notify us in writing that you wish to change these instructions. You can ask for this form at the Admission's Office or call (218) 728-7500 and ask for The Hills Youth and Family Services Compliance Officer.

**To Avert a Serious Threat of Harm:** Under certain circumstances, we may use and disclose health information about you when necessary to prevent a serious and imminent threat to the health and safety of you, another person, or the general public.

**Military Authorities/National Security:** We may release protected health information to authorized federal officials for military intelligence, counterintelligence, or other national security activities authorized by law. The Hills Youth and Family Services may also disclose protected health information to authorized federal officials so they may provide protection to the President or other authorized individuals. No consent is required if the disclosure is specifically required by federal law.

**Public Health Activities:** We may discuss health information about you for legally authorized or required public health activities such as in cases of “mandatory reporting” of abuse or neglect. These may also include such things as preventing or controlling disease, reporting reactions to medications, or notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
Health Oversight Activities: We may disclose health information to a health oversight agency for legally authorized activities, such as audits, investigations, inspections, and licensure. Through these activities the government monitors the health care system, government programs, and compliance with applicable laws and regulations, including civil rights laws.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Law Enforcement Activities: We may disclose your health information to the police or other law enforcement officials as required or permitted by law, including in response to a court order, subpoena, summons, warrant, or similar process. If we reasonably believe you are a victim of abuse, neglect, or domestic violence and the reporting of such information is required or allowed by law, we may disclose your health information to a government authority, including a social service or protective service agency. No consent is required if the disclosure is in response to a valid court order or warrant.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any judicial or administrative proceeding as required or permitted by law, including in response to a court/administrative order, subpoena or similar process.

Death: In case of your death, information about you may be released to your relatives or to facilitate organ donations.

Coroner, Medical Examiners, and Funeral Directors: We may disclose health information to a coroner or medical examiner when necessary to identify the deceased, determine the cause of death, or as otherwise authorized by law. The Hills Youth and Family Services also may release protected health information to a funeral director as necessary to carry out the funeral director’s duties, including arrangements in reasonable anticipation of and after death.

Civil Commitment: Certain information related to pre-petition screening may be released without your consent.

Correctional Programs: We may release information about you if you are in custody to provide you with health care, to protect your health, or to protect the health of others.

Required By Other Laws: We will use or disclose health information when required by other federal, state or local laws.

Alcohol and Drug Abuse Records: If you are a recipient of alcohol or drug abuse treatment, provided by a federally assisted alcohol and drug abuse program, your health information is protected by special federal confidentiality laws (42 CFR Part 2). Your health information will be disclosed to The Hills Youth and Family Services staff and representatives within the alcohol or drug abuse treatment program and certain organizations providing services to the program that have a need to know your health information to perform their job duties or to medical personnel in the event of a medical emergency.

Information with Additional Protections: Certain types of health information may have additional protection under federal or state law. These types of information will not be released without your express permission.
Individual Rights

This section describes your rights as a The Hills Youth and Family Services patient related to your health information:

Right to Inspect and Copy: You have the right to request in writing that you see and obtain a copy of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances (for example, we may deny access if your physician believes it will be harmful to your health or could cause a threat to others), you may request that the denial be reviewed. If such a review is agreed upon, another licensed health care professional chosen by The Hills Youth and Family Services may review your request, and we will comply with the outcome of that review. To make such a request, please contact The Hills Youth and Family Services Compliance Officer at (218) 728-7500.

Right to Refuse to Provide Information: You have the right to refuse to provide information. If you exercise this right, we may not be able to provide services to you.

Please Note: Minnesota law requires a written and legally compliant patient consent for disclosures of health information to the patient themselves. Therefore, the proper The Hills Youth and Family Services form must be completed and received prior to such access being granted.

Right to Request Alternate Methods of Communication: You have the right to request, in writing, but without needing to state a reason, that confidential communication about you be made in an alternative manner (such as by phone or email) or at a certain location. We will accommodate reasonable requests. Your request must specify how or where you wish to be contacted in the future. To make such a request, please contact The Hills Youth and Family Services Compliance Officer at (218) 728-7500.

Right to Request Amendment: If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to amend information. The request should state the reason for the amendment and specify the information to be amended. Any amendment we make to your health information will be disclosed to those with whom we previously disclosed the amended information.

We may deny your request for an amendment if the request is not in writing or does not state a reason. We may also deny your request if the information to be amended was not created by The Hills Youth and Family Services (unless the creator of the information is no longer available to amend it), is no longer maintained by The Hills Youth and Family Services, is not part of the information which you would be permitted to see and copy, or is accurate and complete. We will notify you in a timely manner of our response to your request for amendment. If we deny your request, you may submit a statement disagreeing with our denial, and you may direct that your request for amendment and our denial be included with any future disclosures of the information you requested to amend. If you submit a statement of disagreement, we may prepare and provide you with a copy of a written statement of rebuttal, and your statement of disagreement and our rebuttal will be included in subsequent disclosures of the information. To make such a request, please contact The Hills Youth and Family Services Compliance Officer at (218) 728-7500.

Right to Request Restrictions: You have a right to request a restriction or limitation on the medical information we use and disclose about you for treatment, payment of health care operations, or to assist others’ involvement in your care. Your request must be in writing, state the restrictions that you are requesting, and state to whom the restrictions apply. Please
note that The Hills Youth and Family Services may not be legally required to honor such a request. To make such a request, please contact The Hills Youth and Family Services Compliance Officer at (218) 728-7500.

**Right to Receive an Accounting of Disclosures:** We keep a log of information about you that has been disclosed to third parties other than for treatment, payment and health care operations. You may obtain a list of such disclosures over the past six years by sending a written request to The Hills Youth and Family Services Compliance Officer at (218) 728-7500.

**Rights if You Have Made Payment in Full:** If you or someone on your behalf (other than a health plan), has paid for a service in full, you have the right to ask that we not provide information about this service to a health plan for purposes of payment or health care operations. If you ask us to do this, we will not give the information to your health plan.

**Key Information About This Notice**
This Notice takes effect July 1, 2013. It will remain in effect until we replace it. We may change this Notice and make the new changes applicable for all health information we created or received before we made changes to our Notice. We will make any revised Notice available in hard copy and display it in our locations and on our website. Also, you can request the revised Notice in person or by mail. If you have any questions, or would like to discuss this Notice in more detail, please contact The Hills Youth and Family Services Compliance Officer at (218) 728-7500.

**Complaints**
If you are concerned that your privacy rights may have been violated or you disagree with a decision we make about your health information, please contact The Hills Youth and Family Services Compliance Officer at (218) 728-7500. You may also send a written complaint to the United States Department of Health and Human Services-Office of Civil Rights. Our Compliance Officer can provide you with information on how to file such a complaint.

Under no circumstances will we ever ask you to waive your rights under this Notice or retaliate against you in any manner for filing a complaint. The Hills Youth and Family Services reserves the right, however, to take necessary and appropriate action to maintain an environment that serves the best interests of its patients and providers.
Influenza Vaccine
What You Need to Know

1 Why get vaccinated?

Influenza (“flu”) is a contagious disease that spreads around the United States every winter, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu, but the risk of getting flu is highest among children. Symptoms come on suddenly and may last several days. They can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can make some people much sicker than others. These people include young children, people 65 and older, pregnant women, and people with certain health conditions—such as heart, lung or kidney disease, nervous system disorders, or a weakened immune system. Flu vaccination is especially important for these people, and anyone in close contact with them.

Flu can also lead to pneumonia, and make existing medical conditions worse. It can cause diarrhea and seizures in children.

Each year thousands of people in the United States die from flu, and many more are hospitalized.

Flu vaccine is the best protection against flu and its complications. Flu vaccine also helps prevent spreading flu from person to person.

2 Inactivated and recombinant flu vaccines

You are getting an injectable flu vaccine, which is either an “inactivated” or “recombinant” vaccine. These vaccines do not contain any live influenza virus. They are given by injection with a needle, and often called the “flu shot.”

A different, live, attenuated (weakened) influenza vaccine is sprayed into the nostrils. This vaccine is described in a separate Vaccine Information Statement.

Flu vaccination is recommended every year. Some children 6 months through 8 years of age might need two doses during one year.

Flu viruses are always changing. Each year’s flu vaccine is made to protect against 3 or 4 viruses that are likely to cause disease that year. Flu vaccine cannot prevent all cases of flu, but it is the best defense against the disease.

It takes about 2 weeks for protection to develop after the vaccination, and protection lasts several months to a year.

Some illnesses that are not caused by influenza virus are often mistaken for flu. Flu vaccine will not prevent these illnesses. It can only prevent influenza.

Some inactivated flu vaccine contains a very small amount of a mercury-based preservative called thimerosal. Studies have shown that thimerosal in vaccines is not harmful, but flu vaccines that do not contain a preservative are available.

3 Some people should not get this vaccine

Tell the person who gives you the vaccine:

- If you have any severe, life-threatening allergies. If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, including (for example) an allergy to gelatin, antibiotics, or eggs, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.

- If you ever had Guillain-Barré Syndrome (a severe paralyzing illness, also called GBS). Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.

- If you are not feeling well. It is usually okay to get flu vaccine when you have a mild illness, but you might be advised to wait until you feel better. You should come back when you are better.
Risks of a vaccine reaction

With a vaccine, like any medicine, there is a chance of side effects. These are usually mild and go away on their own.

Problems that could happen after any vaccine:
- Brief fainting spells can happen after any medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Severe shoulder pain and reduced range of motion in the arm where a shot was given can happen, very rarely, after a vaccination.
- Severe allergic reactions from a vaccine are very rare, estimated at less than 1 in a million doses. If one were to occur, it would usually be within a few minutes to a few hours after the vaccination.

Mild problems following inactivated flu vaccine:
- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Moderate problems following inactivated flu vaccine:
- Young children who get inactivated flu vaccine and pneumococcal vaccine (PCV13) at the same time may be at increased risk for seizures caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Inactivated flu vaccine does not contain live flu virus, so you cannot get the flu from this vaccine.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

What if there is a serious reaction?

What should I look for?
- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?
- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does not give medical advice.

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.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

How can I learn more?
- Ask your health care 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 website at www.cdc.gov/flu

Vaccine Information Statement (Interim)
Inactivated Influenza Vaccine

08/19/2014
42 U.S.C. § 300aa-26
Tdap Vaccine (Tetanus, Diphtheria, and Pertussis)

What You Need to Know

1. Why get vaccinated?

Tetanus, diphtheria and pertussis can be very serious diseases, even for adolescents and adults. Tdap vaccine can protect us from these diseases.

TETANUS (Lockjaw) causes painful muscle tightening and stiffness, usually all over the body.
- It can lead to tightening of muscles in the head and neck so you can’t open your mouth, swallow, or sometimes even breathe. Tetanus kills about 1 out of 5 people who are infected.

DIPHTHERIA can cause a thick coating to form in the back of the throat.
- It can lead to breathing problems, paralysis, heart failure, and death.

PERTUSSIS (Whooping Cough) causes severe coughing spells, which can cause difficulty breathing, vomiting and disturbed sleep.
- It can also lead to weight loss, incontinence, and rib fractures. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications, which could include pneumonia or death.

These diseases are caused by bacteria. Diphtheria and pertussis are spread from person to person through coughing or sneezing. Tetanus enters the body through cuts, scratches, or wounds.

Before vaccines, the United States saw as many as 200,000 cases a year of diphtheria and pertussis, and hundreds of cases of tetanus. Since vaccination began, tetanus and diphtheria have dropped by about 99% and pertussis by about 80%.

2. Tdap vaccine

Tdap vaccine can protect adolescents and adults from tetanus, diphtheria, and pertussis. One dose of Tdap is routinely given at age 11 or 12. People who did not get Tdap at that age should get it as soon as possible.

Tdap is especially important for health care professionals and anyone having close contact with a baby younger than 12 months.

Pregnant women should get a dose of Tdap during every pregnancy, to protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

A similar vaccine, called Td, protects from tetanus and diphtheria, but not pertussis. A Td booster should be given every 10 years. Tdap may be given as one of these boosters if you have not already gotten a dose. Tdap may also be given after a severe cut or burn to prevent tetanus infection.

Your doctor can give you more information.

Tdap may safely be given at the same time as other vaccines.

3. Some people should not get this vaccine

- If you ever had a life-threatening allergic reaction after a dose of any tetanus, diphtheria, or pertussis containing vaccine, OR if you have a severe allergy to any part of this vaccine, you should not get Tdap. Tell your doctor if you have any severe allergies.
- If you had a coma, or long or multiple seizures within 7 days after a childhood dose of DTP or DTaP, you should not get Tdap, unless a cause other than the vaccine was found. You can still get Td.
- Talk to your doctor if you:
  - have epilepsy or another nervous system problem,
  - had severe pain or swelling after any vaccine containing diphtheria, tetanus or pertussis,
  - ever had Guillain-Barré Syndrome (GBS),
  - aren’t feeling well on the day the shot is scheduled.
Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own, but serious reactions are also possible.

Brief fainting spells can follow a vaccination, leading to injuries from falling. Sitting or lying down for about 15 minutes can help prevent these. Tell your doctor if you feel dizzy or light-headed, or have vision changes or ringing in the ears.

Mild problems following Tdap

(Did not interfere with activities)

- Pain where the shot was given (about 3 in 4 adolescents or 2 in 3 adults)
- Redness or swelling where the shot was given (about 1 person in 5)
- Mild fever of at least 100.4°F (up to about 1 in 25 adolescents or 1 in 100 adults)
- Headache (about 3 or 4 people in 10)
- Tiredness (about 1 person in 3 or 4)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 in 4 adolescents or 1 in 10 adults)
- Chills, body aches, sore joints, rash, swollen glands (uncommon)

Moderate problems following Tdap

(Interfered with activities, but did not require medical attention)

- Pain where the shot was given (about 1 in 5 adolescents or 1 in 100 adults)
- Redness or swelling where the shot was given (up to about 1 in 16 adolescents or 1 in 25 adults)
- Fever over 102°F (about 1 in 100 adolescents or 1 in 250 adults)
- Headache (about 3 in 20 adolescents or 1 in 10 adults)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 or 3 people in 100)
- Swelling of the entire arm where the shot was given (up to about 3 in 100).

Severe problems following Tdap

(Unable to perform usual activities; required medical attention)

- Swelling, severe pain, bleeding and redness in the arm where the shot was given (rare).

A severe allergic reaction could occur after any vaccine (estimated less than 1 in a million doses).

What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.
- Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the “Vaccine Adverse Event Reporting System” (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS is only for reporting reactions. They do not give medical advice.

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.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation.

How can I learn more?

- Ask your doctor.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 or visit CDC’s website at www.cdc.gov/vaccines

Vaccine Information Statement (Interim)

Tdap Vaccine

05/09/2013

42 U.S.C. § 300aa-26
HPV Vaccine  
Gardasil® (Human Papillomavirus)

What You Need to Know

1. What is HPV?

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. More than half of sexually active men and women are infected with HPV at some time in their lives.

About 20 million Americans are currently infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact.

Most HPV infections don’t cause any symptoms, and go away on their own. But HPV can cause cervical cancer in women. Cervical cancer is the 2nd leading cause of cancer deaths among women around the world. In the United States, about 12,000 women get cervical cancer every year and about 4,000 are expected to die from it.

HPV is also associated with several less common cancers, such as vaginal and vulvar cancers in women, and anal and oropharyngeal (back of the throat, including base of tongue and tonsils) cancers in both men and women. HPV can also cause genital warts and warts in the throat.

There is no cure for HPV infection, but some of the problems it causes can be treated.

2. HPV vaccine: Why get vaccinated?

The HPV vaccine you are getting is one of two vaccines that can be given to prevent HPV. It may be given to both males and females.

This vaccine can prevent most cases of cervical cancer in females, if it is given before exposure to the virus. In addition, it can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

Protection from HPV vaccine is expected to be long-lasting. But vaccination is not a substitute for cervical cancer screening. Women should still get regular Pap tests.

3. Who should get this HPV vaccine and when?

**HPV vaccine is given as a 3-dose series**

<table>
<thead>
<tr>
<th>Dose</th>
<th>Schedule</th>
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<tbody>
<tr>
<td>1st Dose</td>
<td>Now</td>
</tr>
<tr>
<td>2nd Dose</td>
<td>1 to 2 months after Dose 1</td>
</tr>
<tr>
<td>3rd Dose</td>
<td>6 months after Dose 1</td>
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</tbody>
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Additional (booster) doses are not recommended.

**Routine vaccination**

- This HPV vaccine is recommended for girls and boys **11 or 12 years of age**. It may be given starting at age 9.

**Why is HPV vaccine recommended at 11 or 12 years of age?**

HPV infection is easily acquired, even with only one sex partner. That is why it is important to get HPV vaccine before any sexual contact takes place. Also, response to the vaccine is better at this age than at older ages.

**Catch-up vaccination**

This vaccine is recommended for the following people who have not completed the 3-dose series:

- Females 13 through 26 years of age.
- Males 13 through 21 years of age.

This vaccine may be given to men 22 through 26 years of age who have not completed the 3-dose series.

It is recommended for men through age 26 who have sex with men or whose immune system is weakened because of HIV infection, other illness, or medications.

HPV vaccine may be given at the same time as other vaccines.
4 Some people should not get HPV vaccine or should wait.

- Anyone who has ever had a life-threatening allergic reaction to any component of HPV vaccine, or to a previous dose of HPV vaccine, should not get the vaccine. Tell your doctor if the person getting vaccinated has any severe allergies, including an allergy to yeast.
- HPV vaccine is not recommended for pregnant women. However, receiving HPV vaccine when pregnant is not a reason to consider terminating the pregnancy. Women who are breast feeding may get the vaccine.
- People who are mildly ill when a dose of HPV vaccine is planned can still be vaccinated. People with a moderate or severe illness should wait until they are better.

5 What are the risks from this vaccine?

This HPV vaccine has been used in the U.S. and around the world for about six years and has been very safe.

However, any medicine could possibly cause a serious problem, such as a severe allergic reaction. The risk of any vaccine causing a serious injury, or death, is extremely small.

Life-threatening allergic reactions from vaccines are very rare. If they do occur, it would be within a few minutes to a few hours after the vaccination.

Several mild to moderate problems are known to occur with this HPV vaccine. These do not last long and go away on their own.

- Reactions in the arm where the shot was given:
  - Pain (about 8 people in 10)
  - Redness or swelling (about 1 person in 4)
- Fever:
  - Mild (100°F) (about 1 person in 10)
  - Moderate (102°F) (about 1 person in 65)
- Other problems:
  - Headache (about 1 person in 3)
- Fainting: Brief fainting spells and related symptoms (such as jerking movements) can happen after any medical procedure, including vaccination. Sitting or lying down for about 15 minutes after a vaccination can help prevent fainting and injuries caused by falls. Tell your doctor if the patient feels dizzy or light-headed, or has vision changes or ringing in the ears.

Like all vaccines, HPV vaccines will continue to be monitored for unusual or severe problems.

6 What if there is a serious reaction?

What should I look for?
- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?
- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS is only for reporting reactions. They do not give medical advice.

7 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.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation.

8 How can I learn more?

- Ask your doctor.
- 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 website at www.cdc.gov/vaccines

Vaccine Information Statement (Interim)
HPV Vaccine (Gardasil)

5/17/2013

42 U.S.C. § 300aa-26
Hepatitis A Vaccine
What You Need to Know

1. What is hepatitis A?

Hepatitis A is a serious liver disease caused by the hepatitis A virus (HAV). HAV is found in the stool of people with hepatitis A.

It is usually spread by close personal contact and sometimes by eating food or drinking water containing HAV. A person who has hepatitis A can easily pass the disease to others within the same household.

Hepatitis A can cause:
- “flu-like” illness
- jaundice (yellow skin or eyes, dark urine)
- severe stomach pains and diarrhea (children)

People with hepatitis A often have to be hospitalized (up to about 1 person in 5).

Adults with hepatitis A are often too ill to work for up to a month.

Sometimes, people die as a result of hepatitis A (about 3–6 deaths per 1,000 cases).

Hepatitis A vaccine can prevent hepatitis A.

2. Who should get hepatitis A vaccine and when?

WHO

Some people should be routinely vaccinated with hepatitis A vaccine:
- All children between their first and second birthdays (12 through 23 months of age).
- Anyone 1 year of age and older traveling to or working in countries with high or intermediate prevalence of hepatitis A, such as those located in Central or South America, Mexico, Asia (except Japan), Africa, and eastern Europe. For more information see www.cdc.gov/travel.
- Children and adolescents 2 through 18 years of age who live in states or communities where routine vaccination has been implemented because of high disease incidence.
- Men who have sex with men.
- People who use street drugs.
- People with chronic liver disease.
- People who are treated with clotting factor concentrates.
- People who work with HAV-infected primates or who work with HAV in research laboratories.
- Members of households planning to adopt a child, or care for a newly arriving adopted child, from a country where hepatitis A is common.

Other people might get hepatitis A vaccine in certain situations (ask your doctor for more details):
- Unvaccinated children or adolescents in communities where outbreaks of hepatitis A are occurring.
- Unvaccinated people who have been exposed to hepatitis A virus.
- Anyone 1 year of age or older who wants protection from hepatitis A.

Hepatitis A vaccine is not licensed for children younger than 1 year of age.

WHEN

For children, the first dose should be given at 12 through 23 months of age. Children who are not vaccinated by 2 years of age can be vaccinated at later visits.

For others at risk, the hepatitis A vaccine series may be started whenever a person wishes to be protected or is at risk of infection.

For travelers, it is best to start the vaccine series at least one month before traveling. (Some protection may still result if the vaccine is given on or closer to the travel date.)

Two doses of the vaccine are needed for lasting protection. These doses should be given at least 6 months apart.

Hepatitis A vaccine may be given at the same time as other vaccines.
Some people should not get hepatitis A vaccine or should wait.

- Anyone who has ever had a severe (life threatening) allergic reaction to a previous dose of hepatitis A vaccine should not get another dose.
- Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine.
- Tell your doctor if you have any severe allergies, including a severe allergy to latex. All hepatitis A vaccines contain alum, and some hepatitis A vaccines contain 2-phenoxyethanol.
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover. Ask your doctor. People with a mild illness can usually get the vaccine.
- Tell your doctor if you are pregnant. Because hepatitis A vaccine is inactivated (killed), the risk to a pregnant woman or her unborn baby is believed to be very low. But your doctor can weigh any theoretical risk from the vaccine against the need for protection.

What are the risks from hepatitis A vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of hepatitis A vaccine causing serious harm, or death, is extremely small.

Getting hepatitis A vaccine is much safer than getting the disease.

Mild problems
- soreness where the shot was given (about 1 out of 2 adults, and up to 1 out of 6 children)
- headache (about 1 out of 6 adults and 1 out of 25 children)
- loss of appetite (about 1 out of 12 children)
- tiredness (about 1 out of 14 adults)

If these problems occur, they usually last 1 or 2 days.

Severe problems
- serious allergic reaction, within a few minutes to a few hours after the shot (very rare).

What if there is a serious reaction?

What should I look for?
- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?
- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS is only for reporting reactions. They do not give medical advice.

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Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation.

How can I learn more?
- Ask your doctor.
- 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 website at www.cdc.gov/vaccines

Vaccine Information Statement (Interim)
Hepatitis A Vaccine

10/25/2011

42 U.S.C. § 300aa-26
Hepatitis B Vaccine

What You Need to Know

1. What is hepatitis B?

Hepatitis B is a serious infection that affects the liver. It is caused by the hepatitis B virus.

- In 2009, about 38,000 people became infected with hepatitis B.
- Each year about 2,000 to 4,000 people die in the United States from cirrhosis or liver cancer caused by hepatitis B.

Hepatitis B can cause:

**Acute (short-term) illness.** This can lead to:
- loss of appetite
- diarrhea and vomiting
- tiredness
- jaundice (yellow skin or eyes)
- pain in muscles, joints, and stomach

Acute illness, with symptoms, is more common among adults. Children who become infected usually do not have symptoms.

**Chronic (long-term) infection.** Some people go on to develop chronic hepatitis B infection. Most of them do not have symptoms, but the infection is still very serious, and can lead to:
- liver damage (cirrhosis)
- liver cancer
- death

Chronic infection is more common among infants and children than among adults. People who are chronically infected can spread hepatitis B virus to others, even if they don’t look or feel sick. Up to 1.4 million people in the United States may have chronic hepatitis B infection.

Hepatitis B virus is easily spread through contact with the blood or other body fluids of an infected person. People can also be infected from contact with a contaminated object, where the virus can live for up to 7 days.

- A baby whose mother is infected can be infected at birth;
- Children, adolescents, and adults can become infected by:
  - contact with blood and body fluids through breaks in the skin such as bites, cuts, or sores;
  - contact with objects that have blood or body fluids on them such as toothbrushes, razors, or monitoring and treatment devices for diabetes;
  - having unprotected sex with an infected person;
  - sharing needles when injecting drugs;
  - being stuck with a used needle.

2. Hepatitis B vaccine: Why get vaccinated?

Hepatitis B vaccine can prevent hepatitis B, and the serious consequences of hepatitis B infection, including liver cancer and cirrhosis.

Hepatitis B vaccine may be given by itself or in the same shot with other vaccines.

Routine hepatitis B vaccination was recommended for some U.S. adults and children beginning in 1982, and for all children in 1991. Since 1990, new hepatitis B infections among children and adolescents have dropped by more than 95%—and by 75% in other age groups.

Vaccination gives long-term protection from hepatitis B infection, possibly lifelong.

3. Who should get hepatitis B vaccine and when?

**Children and adolescents**

- Babies normally get 3 doses of hepatitis B vaccine:
  - 1st Dose: Birth
  - 2nd Dose: 1-2 months of age
  - 3rd Dose: 6-18 months of age

Some babies might get 4 doses, for example, if a combination vaccine containing hepatitis B is used. (This is a single shot containing several vaccines.) The extra dose is not harmful.

- Anyone through 18 years of age who didn’t get the vaccine when they were younger should also be vaccinated.

**Adults**

- All unvaccinated adults at risk for hepatitis B infection should be vaccinated. This includes:
  - sex partners of people infected with hepatitis B,
  - men who have sex with men,
  - people who inject street drugs,
  - people with more than one sex partner,
  - people with chronic liver or kidney disease,
  - people under 60 years of age with diabetes,
  - people with jobs that expose them to human blood or other body fluids,
- household contacts of people infected with hepatitis B, residents and staff in institutions for the developmentally disabled, kidney dialysis patients, people who travel to countries where hepatitis B is common, people with HIV infection.

- Other people may be encouraged by their doctor to get hepatitis B vaccine; for example, adults 60 and older with diabetes. Anyone else who wants to be protected from hepatitis B infection may get the vaccine.

- Pregnant women who are at risk for one of the reasons stated above should be vaccinated. Other pregnant women who want protection may be vaccinated. Adults getting hepatitis B vaccine should get 3 doses—with the second dose given 4 weeks after the first and the third dose 5 months after the second. Your doctor can tell you about other dosing schedules that might be used in certain circumstances.

**4 Who should not get hepatitis B vaccine?**

- Anyone with a life-threatening allergy to yeast, or to any other component of the vaccine, should not get hepatitis B vaccine. Tell your doctor if you have any severe allergies.

- Anyone who has had a life-threatening allergic reaction to a previous dose of hepatitis B vaccine should not get another dose.

- Anyone who is moderately or severely ill when a dose of vaccine is scheduled should probably wait until they recover before getting the vaccine.

Your doctor can give you more information about these precautions.

Note: You might be asked to wait 28 days before donating blood after getting hepatitis B vaccine. This is because the screening test could mistake vaccine in the bloodstream (which is not infectious) for hepatitis B infection.

**5 What are the risks from hepatitis B vaccine?**

Hepatitis B is a very safe vaccine. Most people do not have any problems with it.

The vaccine contains non-infectious material, and cannot cause hepatitis B infection.

Some mild problems have been reported:

- Soreness where the shot was given (up to about 1 person in 4).

- Temperature of 99.9°F or higher (up to about 1 person in 15).

Severe problems are extremely rare. Severe allergic reactions are believed to occur about once in 1.1 million doses.

A vaccine, like any medicine, could cause a serious reaction. But the risk of a vaccine causing serious harm, or death, is extremely small. More than 100 million people in the United States have been vaccinated with hepatitis B vaccine.

**6 What if there is a serious reaction?**

**What should I look for?**

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

**What should I do?**

- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.

- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at [www.vaers.hhs.gov](http://www.vaers.hhs.gov), or by calling 1-800-822-7967.

VAERS is only for reporting reactions. They do not give medical advice.

**7 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.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation).

**8 How can I learn more?**

- Ask your doctor.

- 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 website at [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines)

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Vaccine Information Statement (Interim)  
Hepatitis B Vaccine  
2/2/2012  
42 U.S.C. § 300aa-26
## What You Need to Know

### 1 What is meningococcal disease?

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.

Meningococcal disease also causes blood infections. About 1,000–1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10–15% of these people die. Of those who live, another 11%–19% lose their arms or legs, have problems with their nervous systems, become deaf, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16–21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

### 2 Meningococcal vaccine

There are two kinds of meningococcal vaccine in the U.S.:

- Meningococcal conjugate vaccine (MCV4) is the preferred vaccine for people 55 years of age and younger.

- Meningococcal polysaccharide vaccine (MPSV4) has been available since the 1970s. It is the only meningococcal vaccine licensed for people older than 55.

Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. There are other types of meningococcal disease; the vaccines do not protect against these.

### 3 Who should get meningococcal vaccine and when?

**Routine vaccination**

Two doses of MCV4 are recommended for adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16.

Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

**Other people at increased risk**

- College freshmen living in dormitories.
- Laboratory personnel who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has persistent complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

Children between 9 and 23 months of age, and anyone else with certain medical conditions need 2 doses for adequate protection. Ask your doctor about the number and timing of doses, and the need for booster doses.

MCV4 is the preferred vaccine for people in these groups who are 9 months through 55 years of age. MPSV4 can be used for adults older than 55.
Some people should not get meningococcal vaccine or should wait.

- Anyone who has ever had a severe (life-threatening) allergic reaction to a previous dose of MCV4 or MPSV4 vaccine should not get another dose of either vaccine.
- Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine. Tell your doctor if you have any severe allergies.
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover. Ask your doctor. People with a mild illness can usually get the vaccine.
- Meningococcal vaccines may be given to pregnant women. MCV4 is a fairly new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed. The manufacturers of MCV4 maintain pregnancy registries for women who are vaccinated while pregnant.

Except for children with sickle cell disease or without a working spleen, meningococcal vaccines may be given at the same time as other vaccines.

What are the risks from meningococcal vaccines?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.

Brief fainting spells and related symptoms (such as jerking or seizure-like movements) can follow a vaccination. They happen most often with adolescents, and they can result in falls and injuries.

Sitting or lying down for about 15 minutes after getting the shot—especially if you feel faint—can help prevent these injuries.

Mild problems

As many as half the people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

A small percentage of people who receive the vaccine develop a mild fever.

Severe problems

Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.

What if there is a serious reaction?

What should I look for?

Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
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How can I learn more?

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Vaccine Information Statement (Interim)

Meningococcal Vaccine

10/14/2011

42 U.S.C. § 300aa-26
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<th>7-10 YEARS</th>
<th>11-12 YEARS</th>
<th>13-18 YEARS</th>
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<tbody>
<tr>
<td>Tdap ¹</td>
<td>Tetanus, Diphtheria, Pertussis (Tdap) Vaccine</td>
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<tr>
<td></td>
<td>Human Papillomavirus (HPV) Vaccine (3 Doses)²</td>
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<td>MCV4</td>
<td>Meningococcal Conjugate Vaccine (MCV4) Dose ³</td>
<td>MCV4 Dose ³</td>
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<td>Influenza (Yearly)⁴</td>
<td>Booster at age 16 years</td>
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<td>Pneumococcal Vaccine⁵</td>
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<td>Hepatitis A (HepA) Vaccine Series⁶</td>
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<td>Measles, Mumps, Rubella (MMR) Vaccine Series</td>
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<td>Varicella Vaccine Series</td>
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These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

These shaded boxes indicate the vaccine should be given if a child is catching-up on missed vaccines.

These shaded boxes indicate the vaccine is recommended for children with certain health conditions that put them at high risk for serious diseases. Note that healthy children can get the HepA series⁶. See vaccine-specific recommendations at www.cdc.gov/vaccines/pubs/ACIP-list.htm.

**FOOTNOTES**

¹ Tdap vaccine is recommended at age 11 or 12 to protect against tetanus, diphtheria and pertussis. If your child has not received any or all of the DTaP vaccine series, or if you don't know if your child has received these shots, your child needs a single dose of Tdap when they are 7 - 10 years old. Talk to your child's health care provider to find out if they need additional catch-up vaccines.

² All 11 or 12 year olds – both girls and boys – should receive 3 doses of HPV vaccine to protect against HPV-related disease. The full HPV vaccine series should be given as recommended for best protection.

³ Meningococcal conjugate vaccine (MCV) is recommended at age 11 or 12. A booster shot is recommended at age 16. Teens who received MCV for the first time at age 13 through 15 years will need a one-time booster dose between the ages of 16 and 18 years. If your teenager missed getting the vaccine altogether, ask their health care provider about getting it now, especially if your teenager is about to move into a college dorm or military barracks.

⁴ Everyone 6 months of age and older—including preteens and teens—should get a flu vaccine every year. Children under the age of 9 years may require more than one dose. Talk to your child's health care provider to find out if they need more than one dose.

⁵ Pneumococcal Conjugate Vaccine (PCV13) and Pneumococcal Polysaccharide Vaccine (PPSV23) are recommended for some children 6 through 18 years old with certain medical conditions that place them at high risk. Talk to your healthcare provider about pneumococcal vaccines and what factors may place your child at high risk for pneumococcal disease.

⁶ Hepatitis A vaccination is recommended for older children with certain medical conditions that place them at high risk. HepA vaccine is licensed, safe, and effective for all children of all ages. Even if your child is not at high risk, you may decide you want your child protected against HepA. Talk to your healthcare provider about HepA vaccine and what factors may place your child at high risk for HepA.

For more information, call toll free 1-800-CDC-INFO (1-800-232-4636) or visit http://www.cdc.gov/vaccines/teens
**Vaccine-Preventable Diseases and the Vaccines that Prevent Them**

**Diphtheria** *(Can be prevented by Tdap vaccine)*
Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be passed from person to person by direct contact with droplets from an infected person’s cough or sneeze. When people are infected, the diphtheria bacteria produce a toxin (poison) in the body that can cause weakness, sore throat, low-grade fever, and swollen glands in the neck. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In severe cases, the illness can cause coma, paralysis, and even death.

**Hepatitis A** *(Can be prevented by HepA vaccine)*
Hepatitis A is an infection in the liver caused by hepatitis A virus. The virus is spread primarily person-to-person through the fecal-oral route. In other words, the virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces (stool) of an infected person. Symptoms include fever, tiredness, loss of appetite, nausea, abdominal discomfort, dark urine, and jaundice (yellowing of the skin and eyes). An infected person may have no symptoms, may have mild illness for a week or two, or may have severe illness for several months that requires hospitalization. In the U.S., about 100 people a year die from hepatitis A.

**Hepatitis B** *(Can be prevented by HepB vaccine)*
Hepatitis B is an infection of the liver caused by hepatitis B virus. The virus spreads through exchange of blood or other body fluids, for example, from sharing personal items, such as razors or during sex. Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rashes, joint pain, and jaundice. The virus stays in the liver of some people for the rest of their lives and can result in severe liver diseases, including fatal cancer.

**Human Papillomavirus** *(Can be prevented by HPV vaccine)*
Human papillomavirus is a common virus. HPV is most common in people in their teens and early 20s. It is the major cause of cervical cancer in women and genital warts in women and men. The strains of HPV that cause cervical cancer and genital warts are spread during sex.

**Influenza** *(Can be prevented by annual flu vaccine)*
Influenza is a highly contagious viral infection of the nose, throat, and lungs. The virus spreads easily through droplets when an infected person coughs or sneezes and can cause mild to severe illness. Typical symptoms include a sudden high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle pain. Extreme fatigue can last from several days to weeks. Influenza may lead to hospitalization or even death, even among previously healthy children.

**Measles** *(Can be prevented by MMR vaccine)*
Measles is one of the most contagious viral diseases. Measles virus is spread by direct contact with the airborne respiratory droplets of an infected person. Measles is so contagious that just being in the same room after a person who has measles has already left can result in infection. Symptoms usually include a rash, fever, cough, and red, watery eyes. Fever can persist, rash can last for up to a week, and coughing can last about 10 days. Measles can also cause pneumonia, seizures, brain damage, or death.

**Meningococcal Disease** *(Can be prevented by MCV vaccine)*
Meningococcal disease is caused by bacteria and is a leading cause of bacterial meningitis (infection around the brain and spinal cord) in children. The bacteria are spread through the exchange of nose and throat droplets, such as when coughing, sneezing or kissing. Symptoms include nausea, vomiting, sensitivity to light, confusion and sleepiness. Meningococcal disease is a leading cause in infants. About one of every ten people who get the disease dies from it. Survivors of meningococcal disease may lose their arms or legs, become deaf, have problems with their nervous systems, become developmentally disabled, or suffer seizures or strokes.

**Pertussis** *(Whooping cough)* *(Can be prevented by Tdap vaccine)*
Pertussis is caused by bacteria spread through direct contact with respiratory droplets when an infected person coughs or sneezes. In the beginning, symptoms of pertussis are similar to the common cold, including runny nose, sneezing, and cough. After 1-2 weeks, pertussis can cause spells of violent coughing and choking, making it hard to breathe, drink, or eat. This cough can last for weeks. Pertussis is most serious for babies, who can get pneumonia, have seizures, become brain damaged, or even die. About two-thirds of children under 1 year of age who get pertussis must be hospitalized.

**Pneumococcal Disease** *(Can be prevented by Pneumococcal vaccine)*
Pneumonia is an infection of the lungs that can be caused by the bacteria called pneumococcus. This bacteria can cause other types of infections too, such as ear infections, sinus infections, meningitis (infection of the covering around the brain and spinal cord), bacteremia and sepsis (bloodstream infection). Sinus and ear infections are usually mild and are much more common than the more severe forms of pneumococcal disease. However, in some cases pneumococcal disease can be fatal or result in long-term problems, like brain damage, hearing loss and limb loss. Pneumococcal disease spreads when people cough or sneeze. Many people have the bacteria in their nose or throat at one time or another without being ill—this is known as being a carrier.

**Polio** *(Can be prevented by IPV vaccine)*
Polio is caused by a virus that lives in an infected person’s throat and intestines. It spreads through contact with the feces (stool) of an infected person and through droplets from a sneeze or cough. Symptoms typically include sudden fever, sore throat, headache, muscle weakness, and pain. In about 1% of cases, polio can cause paralysis. Among those who are paralyzed, up to 5% of children may die because they become unable to breathe.

**Rubella** *(German Measles)* *(Can be prevented by MMR vaccine)*
Rubella is caused by a virus that is spread through coughing and sneezing. In children rubella usually causes a mild illness with fever, swollen glands, and a rash that lasts about 3 days. Rubella rarely causes serious illness or complications in children, but it can be very serious to a baby in the womb. If a pregnant woman is infected, the result to the baby can be devastating, including miscarriage, serious heart defects, mental retardation and loss of hearing and eye sight.

**Tetanus** *(Lockjaw)* *(Can be prevented by Tdap vaccine)*
Tetanus is caused by bacteria found in soil. The bacteria enters the body through a wound, such as a deep cut. When people are infected, the bacteria produce a toxin (poison) in the body that causes serious, painful spasms and stiffness of all muscles in the body. This can lead to “locking” of the jaw so a person cannot open his or her mouth, swallow, or breathe. Complete recovery from tetanus can take months. Ten of people who get tetanus die from the disease.

**Varicella** *(Chickenpox)* *(Can be prevented by varicella vaccine)*
Chickenpox is caused by the varicella zoster virus. Chickenpox is very contagious and spreads very easily from infected people. The virus can spread from either a cough, sneeze. It can also spread from the blisters on the skin, either by touching them or by breathing in these viral particles. Typical symptoms of chickenpox include an itchy rash with blisters, tiredness, headache and fever. Chickenpox is usually mild, but it can lead to severe skin infections, pneumonia, encephalitis (brain swelling), or even death.

If you have any questions about your child’s vaccines, talk to your healthcare provider.