PHOCIS Client Information Worksheet

CLIENT DEMOGRAPHICS

Legal Name (Last, First, Middle):

Suffix (Jr., Sr., III):

Date of Birth (MM/DD/YYYY):

Social Security Number (SSN):

Gender: ☐ Female ☐ Male ☐ Other

Birth Country:

Birth State:

Primary Language: ☐ English ☐ Spanish ☐ American Sign ☐ Other: _____

Foster Child: ☐ Yes ☐ No

Race:
☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian/ Pacific Island
☐ White
☐ Other: _____

Hispanic or Latino:
☐ Yes
☐ No

Marital Status:
☐ Married
☐ Single
☐ Divorced
☐ Widowed
☐ Legally Separated
☐ Unknown

Mother's Maiden Name:

Insurance Type†:
☐ Medicare ☐ No Insurance
☐ Private
☐ Medicaid
†Please show proof of insurance

ADDRESS (please list all that apply)

Street Number and Name	City	State	Zip Code	May we contact you?
Mailing:				☐ Yes ☐ No*
Physical:				☐ Yes ☐ No
Confidential:				*if no contact at mailing, confidential needed

PHONE NUMBERS (at which we may contact you)

10-digit Phone Number	Phone Type (eg., cell, home, emerg)	Contact Name

GUARDIANSHIP (required for ALL clients under 18 years of age)

Name (Last, First, Middle):

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

HOUSEHOLD INCOME

Income: $ _____ per
☐ Year ☐ Month ☐ Twice a Month ☐ Every Other Week
☐ Week ☐ Hour (Numbers of hours worked per week: _____)

Number of people in household supported by income:

PLEASE SIGN AND DATE TO VERIFY INFORMATION IS CORRECT

Signature:

Today's Date:

CLIENT INSURANCE	
Private Insurance Company Name:	
Policy Holder: (First, Middle, Last Name)	
Member ID:	
Group Number:	
Group Name:	
Member's relationship to Policy Holder:	

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____/____/____
month / day / year

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

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

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

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (8/19)

Oklahoma State Department of Health/CHS/Nursing

ODH No. 1048 (Rev. 8/2019)

Information for Healthcare Professionals about the Screening Checklist for Contraindications to Vaccines (Children and Teens)

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references in **Notes** *below.*

NOTE: For supporting documentation on the answers given below, go to the specific ACIP vaccine recommendation found at the following website: www.cdc.gov/vaccines/hcp/acip-recs/index.html

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

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

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

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. For information on vaccines supplied in vials or syringes containing latex, see www.cdc.gov/vaccines-pubs/pinkbook/downloads/appendices/B/latex-table.pdf; for an extensive list of vaccine components, see www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf. People with egg allergy of any severity can receive any recommended influenza vaccine (i.e., any IIV, RIV, or LAIV) that is otherwise appropriate for the patient's age and health status. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administered in a medical setting, such as a clinic, health department, or physician office. Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.[5]

3. Has the child had a serious reaction to a vaccine in the past? *[all vaccines]*

History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses. History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. There are other adverse events that might have occurred following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. Does the child have a long-term health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? *[MMR, MMRV, LAIV, VAR]*

A history of thrombocytopenia or thrombocytopenic purpura is a precaution to MMR and MMRV vaccines. The safety LAIV in children and teens with lung, heart, kidney, or metabolic disease (e.g., diabetes), or a blood disorder has not been established. These conditions, including asthma in children ages 5 years and older, should be considered precautions for the use of LAIV. Children with functional or anatomic asplenia, complement deficiency, cochlear implant, or CSF leak should not receive LAIV. Children on long-term aspirin therapy should not be given LAIV; instead, they should be given IIV. Aspirin use is a precaution to VAR.

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

Children ages 2 through 4 years who have had a wheezing episode within the past 12 months should not be given LAIV. Instead, these children should be given IIV.

6. If your child is a baby, have you ever been told that he or she has had intussusception? *[Rotavirus]*

Infants who have a history of intussusception (i.e., the telescoping of one portion of the intestine into another) should not be given rotavirus vaccine.

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

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

NOTE: For summary information on contraindications and precautions to vaccines, go to the ACIP's General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html

8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? *[LAIV, MMR, MMRV, RV, VAR]*

Live virus vaccines (e.g., MMR, MMRV, VAR, RV, LAIV) are usually contraindicated in immunocompromised children. However, there are exceptions. For example, MMR is recommended for asymptomatic HIV-infected children who do not have evidence of severe immunosuppression. Likewise, VAR should be considered for HIV-infected children age 12 months through 8 years with age-specific CD4+ T-lymphocyte percentage at 15% or greater, or for children age 9 years or older with CD4+ T-lymphocyte counts of greater than or equal to 200 cell/μL. Immunosuppressed children should not receive LAIV. Infants who have been diagnosed with severe combined immunodeficiency (SCID) should not be given a live virus vaccine, including RV. Other forms of immunosuppression are a precaution, not a contraindication, to RV. For details, consult ACIP recommendations (see references in Notes above).

9. Does the child have a parent, brother, or sister with an immune system problem? *[MMR, MMRV, VAR]*

MMR, VAR, and MMRV vaccines should not be given to a child or teen with a family history of congenital or hereditary immunodeficiency in first-degree relatives (i.e., parents, siblings) unless the immune competence of the potential vaccine recipient has been clinically substantiated or verified by a laboratory.

10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? *[LAIV, MMR, MMRV, VAR]*

Live virus vaccines (e.g., LAIV, MMR, MMRV, VAR) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement. Some immune mediator and immune modulator drugs (especially the antitumor-necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. A comprehensive list of immunosuppressive immune modulators is available in CDC Health Information for International Travel (the "Yellow Book") available at wwwnc.cdc.gov/travel/yellowbook/2018/advising-travelers-with-specific-needs/immunocompromised-travelers. The use of live vaccines should be avoided in persons taking these drugs. To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see General Best Practice Guidelines for Immunization (referenced in Notes above). LAIV, when recommended, can be given only to healthy non-pregnant people ages 2 through 49 years.

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

Certain live virus vaccines (e.g., MMR, MMRV, VAR) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations (referenced in Notes above) for the most current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines.

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

Live virus vaccines (e.g., MMR, MMRV, VAR, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active young women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, IPV should not be given during pregnancy; however, it may be given if risk of exposure is imminent (e.g., travel to endemic areas) and immediate protection is needed. IIV and Tdap are both recommended during pregnancy. HPV vaccine is not recommended during pregnancy.

13. Has the child received vaccinations in the past 4 weeks? *[LAIV, MMR, MMRV, VAR, yellow fever]*

Children who were given either LAIV or an injectable live virus vaccine (e.g., MMR, MMRV, VAR, yellow fever) should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at the same time or at any spacing interval.

VACCINE ABBREVIATIONS

LAIV = Live attenuated influenza vaccine
HPV = Human papillomavirus vaccine
IIV = Inactivated influenza vaccine
IPV = Inactivated poliovirus vaccine
MMR = Measles, mumps, and rubella vaccine
MMRV = MMR+VAR vaccine
RIV = Recombinant influenza vaccine
RV = Rotavirus vaccine
Td/Tdap = Tetanus, diphtheria, (acellular pertussis) vaccine
VAR = Varicella vaccine

Consent for Service / Texting / Email

Name _____ **Date of Birth** _____

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma State Department of Health (OSDH) and its entities/contractors. I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions.

I also understand that:

- The information regarding myself and the services I receive will be entered into OSDH information systems and may be used for program evaluation, management, and billing purposes.
- I will not be denied service because of my inability to pay.
- I may refuse service at any time.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: **It is ultimately the client's responsibility to know your coverage and benefits**. You are responsible for any amount not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Some health insurance carriers require the patient to pay a co-pay for services rendered. Payment of the co-pay is expected at the time the service is rendered to the client.

- I authorize the health department (OSDH) to furnish information to my insurance carrier(s) concerning my care.
- I authorize my insurer(s) to pay any benefits directly to the health department. I understand that any amount remaining after such payment has been made by my insurance carrier becomes the client's responsibility.
- I have read the above policy regarding my financial responsibility to the health department for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate.
- I acknowledge that I have received a copy of the *Oklahoma State Department of Health Privacy Statement* as required by the Health Information Portability and Accountability Act (HIPAA). I can also find a copy on the agency website.

CONSENT TO RECEIVE TEXT/EMAILS: The OSDH HIPAA Privacy Notice states that it is my right to accept and/or reject receiving text/emails from the OSDH. By OSDH policy, only appointment reminders, customer surveys and "please contact the office" messages can be sent via SMS texting/email. No lab results or sensitive medical information will be transmitted via text/email. I acknowledge that it is my responsibility to update my contact information with OSDH as needed. I understand that I may opt out of receiving messages at any time by calling the OSDH office.

I authorize the OSDH to send me emails Yes ☐ No ☐ Email address: _____

I authorize the OSDH to send me text messages Yes ☐ No ☐ Cell #: _____

Cell Carrier: _____

_____ _____

Printed Name of Consenter | Relationship to Client (Self/Other – please specify)

_____ _____

Signature of Consenter | Date

_____ _____

Additional Signature (if required) | Date

These messages originate from a secure device but will arrive unencrypted. Your cellphone service provider may charge for delivery of text messages.

Consentimiento para Servicio / Texto / Correo Electrónico

Nombre:_____ Fecha de Nacimiento: _____

Yo, el suscrito, doy consentimiento para los servicios que estoy solicitando del Departamento de Salud del Estado de Oklahoma (OSDH) y sus entidades/contratistas. Yo entiendo que los riesgos y beneficios por estos servicios me serán explicados y tendré la oportunidad de hacer preguntas.
También entiendo que:

- La información referente a mí y a los servicios que recibiré serán ingresados a los sistemas de información del OSDH y pueden ser usados para el programa de evaluación, manejo y propósitos de pagos.
- No se me negaran los servicios debido a mi incapacidad de pagarlos;
- Yo puedo rechazar los servicios en cualquier momento.

AUTORIZACIÓN PARA LA LIBERACIÓN DE INFORMACIÒN Y ASIGNACIÓN DE PAGOS DE TERCER PARTIDO: **Es responsabilidad total del cliente a saber sus beneficios y cobertura**. El cliente es responsable del cualquier balance que no esté incluido en el plan de cobertura. Si su compañía de seguro se niega a pagar cualquier parte de su cuidado, o si Usted elige a continuar los servicios que van más de su cobertura/periodo de póliza, usted será responsable del balance en su totalidad.

Usted es responsable del pago de cualquier deducible y copago/coaseguro según lo determine su contrato con su compañía de seguros. Algunas compañías de seguros exigen que el cliente pague el copago para los servicios cumplidos. Pago se espera en el momento en que se rinde el servicio al cliente.

- Yo autorizo al Departamento de Salud del Estado de Oklahoma (OSDH) a proporcionar la información necesaria a mi compañía de seguros, concerniente a mi cuidado.Yo autorizo a mi seguro médico a pagar todas las prestaciones debidas por tal cuidado, directamente al OSDH. Entiendo que cualquier balance que permanezca después del pago de parte del plan de beneficios de seguros, lo debe el cliente.
- Yo leí la póliza de responsabilidad financiera del departamento de salud para los servicios médicos del cuidado al cliente. Yo certifico que esta información, al mejor de mi conocimiento, es verdad y actual.
- Yo reconozco que he recibido una copia de la Nota de Privacidad del Departamento de Salud del Estado de Oklahoma, tal como es requerido por el Acta de Contabilidad y Portabilidad del Seguro de Salud (HIPAA). También puedo encontrar una copia en el sitio web del Departamento de Salud del Estado de Oklahoma (OSDH)

CONSENTIMIENTO A RECIBIR TEXTO/CORREOS ELECTRÒNICOS: La Nota de Privacidad del Departamento de Salud del Estado de Oklahoma (HIPAA) dice que es mi derecho aceptar o negar textos/correos electrónicos de OSDH. Por póliza de OSDH, solamente recordatorios de citas, encuestas al cliente, y mensajes de "por favor llame a la oficina" se pueden mandar por texto/correo electrónico. Ningún resultado de laboratorio o información sensitivo medico va a ser transmitido vía texto/correo electrónico. Reconozco que es mi responsabilidad actualizar mi información de contacto con OSDH. Entiendo que a cualquier momento puedo llamar a OSDH y optar por no recibir mensajes.

Autorizo OSDH a mandarme correos electrónicos: Si ☐ No ☐ Dirección de Correo Electrónico: _____

Autorizo OSDH a mandarme textos: Si ☐ No ☐ Numero de telefonía móvil: _____

compañía de celular: _____

Escriba el nombre de la persona dando consentimiento

Relación con el cliente (Yo mismo/Otro(Especifique)

Firma de la persona dando consentimiento

Fecha

Firma adicional (si es requerido)

Fecha

Estos mensajes se originan desde un aparato seguro, pero llegarán sin cifrar. Su proveedor de servicios de telefonía celular puede cobrar por la entrega de mensajes de texto.

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

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Tdap vaccine can prevent **tetanus, diphtheria**, and **pertussis.**

Diphtheria and pertussis spread from person to person. Tetanus enters the body through cuts or wounds.

- **TETANUS (T)** causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.
- **DIPHTHERIA (D)** can lead to difficulty breathing, heart failure, paralysis, or death.
- **PERTUSSIS (aP)**, also known as "whooping cough," can cause uncontrollable, violent coughing which makes it hard to breathe, eat, or drink. Pertussis can be extremely serious in babies and young children, causing pneumonia, convulsions, brain damage, or death. In teens and adults, it can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

2 Tdap vaccine

Tdap is only for children 7 years and older, adolescents, and adults.

Adolescents should receive a single dose of Tdap, preferably at age 11 or 12 years.

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.

Adults who have never received Tdap should get a dose of Tdap.

Also, **adults should receive a booster dose every 10 years**, or earlier in the case of a severe and dirty wound or burn. Booster doses can be either Tdap or Td (a different vaccine that protects against tetanus and diphtheria but not pertussis).

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

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria, or pertussis**, or has any **severe, life-threatening allergies.**
- Has had a **coma, decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine (DTP, DTaP, or Tdap).**
- Has **seizures or another nervous system problem.**
- Has ever had **Guillain-Barré Syndrome** (also called GBS).
- Has had **severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diphtheria.**

In some cases, your health care provider may decide to postpone Tdap vaccination to a future visit.

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

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Pain, redness, or swelling where the shot was given, mild fever, headache, feeling tired, and nausea, vomiting, diarrhea, or stomachache sometimes happen after Tdap vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

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

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

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

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your 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/vaccines**