National Immunization Survey – Te	en
Teen Immunization History Questionnaire	



Confidential Information. If received in error, please call 1-800-817-4316.

START HERE Please review your records and complete this questionnaire for the adolescent identified on the label below. Complete pages 1 and 3 only. Return the questionnaire in the postage-paid envelope or fax toll-free to (866) 324-8659. This information is confidential; if faxing, please take extra care to dial the correct number.

1.	Which of the following best describes your immunization records for this adolescent?         You have all or partial immunization records for this adolescent for vaccines given by your practice or other practices.         Was any of the immunization information for this adolescent obtained from your community or state registry?         Yes       No         Other-Explain         You have provided care to this adolescent, but do not have immunization records.		<ul> <li>Which of the following describes this facility?</li> <li>Check all that apply.</li> <li>Private practice (If yes, select <ul> <li>Solo,</li> <li>Group, or</li> <li>Health Maintenance Organization (HMO))</li> </ul> </li> <li>Hospital-based clinic, including university clinic, or residency teaching practice</li> <li>Public health department-operated clinic</li> <li>Community health center</li> <li>Rural Health Clinic</li> <li>Migrant health Center</li> <li>Indian Health Service (IHS)-operated center, Tribal health facility, or urban Indian health care facility</li> <li>Military health care facility (Army, Navy, Air Force, Marines, Coast Guard)</li> <li>WIC clinic</li> <li>School-based health center</li> <li>Pharmacy</li> <li>Non-medical facility that hosted a vaccination clinic run by the health department or other sponsor</li> <li>Other-Explain</li> </ul>
2.	☐ You have no record of providing care to this adolescent.       freturn form as instructed above.         According to your records, what is this adolescent's date of birth?	5d.	<ul> <li>Which of the following best describe the main specialties of this facility? Check all that apply.</li> <li>Pediatrics</li> <li>General Practice</li> <li>Internal Medicine</li> <li>OB/GYN</li> <li>Other-Explain</li> </ul>
3.	What were the dates of this adolescent's <u>first</u> and <u>most</u>	6.	Does your practice order vaccines from your state or local
	Month       Day       Year         First Visit       Image: Don't know         Month       Day       Year         Month       Day       Year         Month       Day       Year         Month       Day       Year         Most       Image: Don't know       Image: Don't know         Recent Visit       Image: Don't know       Image: Don't know	7.	boes your practice order vaccines from your state or local health department to administer to children?         Yes       No       Don't know         Not applicable (Practice does not administer vaccines)         Did you or your facility report any of this adolescent's immunizations to your community or state registry?         Yes       No         Not applicable (No registry in my community/state)         Not applicable (Practice does not administer vaccines)
4.	Did this adolescent receive an 11-12 year old well child         exam or check-up at this place?         Yes       No         Don't know	8.	Contact information for the person returning this form.
5a.	Is your practice a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), or a "look alike" FQHC or RHC? Please see Page 4 for definitions. Yes (Go to 5c) No Don't know		Name:   Image: Nurse     Image: Physician   Image: Nurse     Image: Office Manager/Receptionist   Image: Medical Records     Image: Other   Image: Administrator/Technician
5b.	Has your practice been deputized (sometimes known as delegated authority) to administer Vaccines for Children (VFC) vaccines to underinsured children? Please see Page 4 for definition of a deputized or delegated authority.         Yes       No       Don't know	9.	Phone: (   Fax: (     Go to next page

## Please review the instructions and examples below. Then complete the "Shot Grid" on the next page.

Refer to your vaccination records for the adolescent named on the labels on the front cover and next page of this form.

Record the month, day and year that each type of shot was given.

EXAMPLE								
Vaccine	Dat	Date Given			ther ?	Ту	pe of Vaccine	
	<u>Month</u>	<u>Day</u>	<u>Year</u>		Mark on	e box for each vaccine dos	e received after age 6	
Td/Tdap boosters	1 11	18	2002	] 🗌 Yes 🛛 🗷 N	lo 🗌 Td	□Tdap (Adacel® or Bo	oostrix®)	
received	2			] 🗆 Yes 🛛 N	lo 🗌 Td	□Tdap (Adacel® or Bo	oostrix®)	
after age 6	3			] 🗆 Yes 🛛 N	lo 🗆 Td	Tdap (Adacel® or Bo	oostrix®)	
MMR	1 29	20	2002	] □Yes □N ] ⊠Yes □N		MMR-Varicella	Measles only	
	to mark t practice				der "Giver	by other practice?	?" for vaccinations given by	

Use the "Other" space to enter any vaccines not listed on the next page or any additional doses of listed vaccines that were given to this adolescent (see example below)

0.1	_				_		Please do not	Please enter a description of each vaccine dose
Other	1	11	20	2001	Yes	□No	record Polio, Hib,	TYPHOID
	2				] 🗌 Yes	□No	or Pneumococcal	
							conjugate vaccine (Prevnar <sup>®</sup> ) given	
							before 5 years old	

After completing the "Shot Grid" on the next page, please return this form in the envelope provided.

(Optional) You may also attach a copy of your immunization history records for this adolescent to this form and send it back to NORC at the University of Chicago, National Immunization Survey – Teen, 55 East Monroe Street, 19th Floor, Chicago IL 60603.

Or you may fax the confidential information to (866) 324-8659. If faxing this form, cut along fold to separate pages, then fax pages 1 and 3. Do not fax this page.

## National Immunization Survey – Teen dates in your records for these vaccine types. We realize you might not have the full immunization history of this adolescent.

Manth         Day         Yoar         Make core box for each section data rescale.           1	Vaccine	Da	ite Given	Given l prac	oy othe tice?	er Type of Vaccine				
Preceived after 2			<u>Day</u>	•		Mark one box for each vaccine dose received after age 6				
age 6         2         Institute         Instinstinstitute         In	Td/Tdap boosters	1		□Yes	□No	Td Tdap (Adacel <sup>®</sup> or Boostrix <sup>®</sup> )				
HepB only         HepB inty         HepB inty         HepB inty         LipB-11b         Recomblex         LipB-11b         Colspan="2">LipB-11b         LipB-11b         Accomblex       LipB-11b         Mark one box for each vascine down         Seasonal         LipB-11b         Mark one box for each vascine down         LipB-11b         Mark one box for each vascine down         Mark one box for each vascine down         LipB-11b         Mark one box for each vascine down		2		Yes	□No	Td Tdap (Adacel <sup>®</sup> or Boostrix <sup>®</sup> )				
Hepatitis B. Eccilitation B. B. Serie Structure Structu		3		Yes	□No	Td Tdap (Adacel <sup>®</sup> or Boostrix <sup>®</sup> )				
received since in the provide since in the provided in the pro						HepB only				
Recomblex*       Recomblex*       unknown type       Entroph Network         3       Pres       NN       B 5 mill       Engelitik*       HepB only.       Eltoph Network         4       Pres       NN       B 5 mill       Recomblex*       Engelitik*       HepB only.       HepB only. <td>received since</td> <td>1</td> <td></td> <td>Yes</td> <td>□No</td> <td></td>	received since	1		Yes	□No					
Recombinas*         Recombinas*         unknown type           4         Yes         NN         10.0 ml         10.0 m		2		Yes	□No					
Seasonal Influenza in roceived in tai       Image: Seasonal Influenza in 2		3		🗌 Yes	□No					
Seasonal influenza       1		4		Yes	□No	Recombivax® Recombivax® unknown type				
Influenza received interaz vaccine (IV)       Live Attenuated influenza vaccine (IV)         Preceived interaz vaccine (IV)       Live Attenuated influenza vaccine (IV)         MMR       1       Orss         1       Orss       No         Imachvated influenza vaccine (IV)       Live Attenuated influenza vaccine (IAIV)         Imachvated influenza vaccine (IV)       Live Attenuated influenza vaccine (IAIV)         Imachvated influenza vaccine (IV)       Live Attenuated influenza vaccine (IAIV)         Imachvated influenza vaccine (IV)       Live Attenuated influenza vaccine (IAIV)         Imachvated influenza vaccine (IV)       Live Attenuated influenza vaccine (IAIV)         Imachvated influenza vaccine (IV)       Live Attenuated influenza vaccine (IAIV)         Varicella       1       Orss         2       Orss       No         MMR       MMR-Varicella       Measles only         Varicella only       MMR-Varicella       Measles only         Preumococcal       1       Orss       No         Preumococcal       1       Orss       No         Preumococcal       1       Orss       No         Meningococcal -       1       Orss       No         Meningococcal -       1       Orss       No       MecN4 or MenAcWY	Saacanal					Mark one box for each vaccine dose				
past three years	Influenza	1		Yes	No	Inactivated Influenza Vaccine (IIV) <sup>a</sup>				
MRR         1         Imach vacant         Ima				Yes						
MMR       1       Yes       No       MMR       MMR Varicella       Measles only         Varicella       1       Yes       No       MMR       MMR Varicella       Measles only         Child has a history of chickenpox       1       Yes       No       Yaricella only       MMR-Varicella         Phepatitis A       1       Yes       No       Yaricella only       MMR-Varicella         Preumococcal       2       Yes       No       HepA only (Havrix* or Vaqta")       Yes         2       Yes       No       HepA only (Havrix* or Vaqta")       Yes       No         Pneumococcal       1       Yes       No       HepA only (Havrix* or Vaqta")         2       Yes       No       HepA only (Havrix* or Vaqta")         Pneumococcal       1       Yes       No         2       Yes       No       McCV4 or MenACWY       MPSV4 (Menomune*)         ACWY       Yes       No       McCV4 or MenACWY       MPSV4 (Menomune*)         2       Yes       No       McCV4 or MenACWY       MPSV4 (Menomune*)         4CWY       Yes       No       MenB-FHbp (Trumenba*)       MenB-4C (Bexsero*)         2       Yes       No       MenB-FHbp (Trumenba*)	past three years	3		Yes	□No	Inactivated Influenza Vaccine (IIV) <sup>a</sup> Live Attenuated Influenza Vaccine (LAIV) <sup>b</sup>				
1       1						alnjected, eg. Fluzone®, Fluvirin®, Fluarix®, Afluria®, FluLaval® blnhaled nasal flu spray, eg. FluMist®				
Varicella       1       Image: Second	MMR	1		Yes	□No	MMR MMR-Varicella Measles only				
Image: Index of the second		2		□Yes	□No	MMR MMR-Varicella Measles only				
2       Ves       No       Varicella only       IMRR-Varicella         Child has a history of chickenpox       Image: State only       Image: State only       Image: State only       Image: State only         Hepatitis A       1       Yes       No       Hepatonly (Havrix* or Vaqta*)         2       Yes       No       Hepatonly (Havrix* or Vaqta*)         3       Yes       No       Hepatonly (Havrix* or Vaqta*)         Pneumococcal       1       Yes       No       Please remember to answer all questions on page 1.         Meningococcal       1       Yes       No       MCV4 or MenACWY       MPSV4 (Menomune*)         ACWY       Yes       No       MenB-rHbp (Trumenba*)       MMenB-4C (Bexsero*)         ACWY       Yes       No       MenB-FHbp (Trumenba*)       Image: Addression on page 1.         Meningococcal - 1       Yes       No       MenB-rHbp (Trumenba*)       Image: Addression on page 1.         Meningococcal - 2       Yes       No       MenB-FHbp (Trumenba*)       Image: Addression on page 1.         Meningococcal - 2       Yes       No       MenB-rHbp (Trumenba*)       Image: Addression on page 1.         Menan papillomarius       1       Yes       No       Gardasif (4vHPV)       Gardasif* 9 (9vHPV)       <	Varicella	1								
Child has a history of chickenpox         Hepatitis A       1       Presson         2       Presson       Presson         3       Presson       Presson         2       Presson       Presson         3       Presson       Presson         4       Presson       Presson         4       Presson       Presson         1       Presson       Presson         1       Presson       Presson         1       Presson       Presson         2       Presson       Presson         1       Presson       Presson         1       Presson       Presson         1       Presson       Presson         1       Presson       Presson		2								
Hepatitis A       1       Image: Second Seco	Child has a		of chickenpo							
2       Preumococcal polysaccharide       1       Preumococcal 2       Preumococccal 2       Preumococcccal 2       Preumococcccal 2       Pre		1	1			Hand only (Havriv <sup>®</sup> or Vegta <sup>®</sup> )				
3       Yes       No       HepA only (Havrix* or Vaqta*)         Pneumococcal polysaccharide       1       Yes       No       Please remember to answer all questions on page 1.         Meningococcal - serogroups ACWY       1       Yes       No       MCV4 or MenACWY       MPSV4 (Menomune*)         2       Yes       No       MCV4 or MenACWY       MPSV4 (Menomune*)         8erogroup B       1       Yes       No       MenB-FHbp (Trumenba*)       MenB-4C (Bexsero*)         Human papillomavirus ACWY       1       Yes       No       Gardasil* (4VHPV)       Gardasil* 9 (9VHPV)       Cervarix* (2vHPV)         Yes       No       Gardasil* (4VHPV)       Gardasil* 9 (9VHPV)       Cervarix* (2vHPV)       Cervarix* (2vHPV)         2       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         2       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         2       Yes       No       Garda		2								
Pneumococcal polysaccharide       1		-								
polysaccharide       1       Image: Pression of the pression	Pneumococcal									
Meningococcal ACWY       1       Image: Constraint of the second		1		Yes	□No					
- serogroups ACWY ACWY 2 2 2 2 2 2 2 2 2		2		□Yes	□No	all questions on page 1.				
2       Yes       No       MCV4 or MenACWY (Menactra* or Menveo*)       MPSV4 (Menomune*)         Meningococcal serogroup B       1       Yes       No       MenB-FHbp (Trumenba*)       MenB-4C (Bexsero*)         2       Yes       No       MenB-FHbp (Trumenba*)       MenB-4C (Bexsero*)         3       Yes       No       MenB-FHbp (Trumenba*)       MenB-4C (Bexsero*)         Human papillomavirus (HPV)       1       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         2       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         3       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         0       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         2       Yes       No       Gardasil* 0 (9vHPV)       Cervarix* (2vHPV)       Cervarix* (2vHPV)         3       Yes       No       Please do not record Polio, Hib, or Pneumococccal conjugate vaccine (Prevnar*) given       Image: Corvarix* (2vHPV)       Image: Corvarix* (2vHPV)	Meningococcal - serogroups ACWY	1		Yes	□No					
Meningococcal - serogroup B       1		2			No					
serogroup B       1 <td< td=""><td></td><td>۷</td><td></td><td></td><td></td><td></td></td<>		۷								
Seriegroup B       2       Yes       No       MenB-FHbp (Trumenba*)       MenB-4C (Bexsero*)         Human papillomavirus (HPV)       Yes       No       MenB-FHbp (Trumenba*)       MenB-4C (Bexsero*)         1       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         2       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         3       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         3       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         2       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         3       Yes       No       Gardasil* (4vHPV)       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         4       Yes       No       Please do not record Polio, Hib, or Pneumococcal conjugate vaccine dose       Image: Cord Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar) given       Image: Cord Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar) given	Meningococcal -	1		Yes	No	MenB-FHbp (Trumenba <sup>®</sup> )				
3       Yes       No       MenB-FHbp (Trumenba®)       MenB-4C (Bexsero®)         Human papillomavirus (HPV)       Yes       No       Gardasil® (4vHPV)       Gardasil® 9 (9vHPV)       Cervarix® (2vHPV)         2       Yes       No       Gardasil® (4vHPV)       Gardasil® 9 (9vHPV)       Cervarix® (2vHPV)         3       Yes       No       Gardasil® (4vHPV)       Gardasil® 9 (9vHPV)       Cervarix® (2vHPV)         3       Yes       No       Gardasil® (4vHPV)       Gardasil® 9 (9vHPV)       Cervarix® (2vHPV)         4       Yes       No       Please do not record Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar®) given       Flease do not record Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar®) given	Serogroup B	2								
Human papillomavirus (HPV)       1       Image: Second sec										
papillomavirus (HPV)       1	Human	1								
3       Yes       No       Gardasil* 9 (9vHPV)       Cervarix* (2vHPV)         Other or additional doses of vaccines listed above       1       Yes       No       Please do not record Polio, Hib, or Pneumococcal conjugate vaccine dose         1       Yes       No       Yes       No       Please do not record Polio, Hib, or Pneumococcal conjugate vaccine dose	papillomavirus									
Other or additional doses of vaccines listed above	(116 V)									
Other or additional doses of vaccines listed above 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		3								
additional doses of vaccines listed above       1       Yes       No       Please do not record Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar®) given         4       Yes       No       (Prevnar®) given	Other or		-)()(		_	· ·				
above     2     1/3     1/3     1/4       3     Yes     No     or Pneumococcal conjugate vaccine (Prevnar®) given	additional doses									
3     Image: Second secon	above	<b>۲</b>								
						conjugate vaccine				
5LYes LNo / before 5 years old										
If you need more space to report vaccines, please attach additional sheets.										





**Centers for Disease Control and Prevention** 

U.S. Department of Health and Human Services

Thank you for your help with this important study!

If you would like more information about the National Center for Immunization and Respiratory Diseases, including information about vaccine recommendations, or data and statistics from previous years of the National Immunization Survey, please visit the CDC Vaccines & Immunization website at <u>www.cdc.gov/vaccines</u>.

If you would like more information about the National Immunization Survey, please visit the National Immunization Survey website at <u>http://www.cdc.gov/nchs/nis.htm</u>. If you have any questions or comments about this study, please call (800) 817-4316 or email nis@cdc.gov.

Note: Do NOT send any confidential patient information, such as patient's name or date of birth, in an email message.

## **Definitions:**

**Federally Qualified Health Center (FQHC):** A Federally Qualified Health Center as defined under section 1905(I)(2) of the Social Security Act. FQHCs receive grants under Section 330 of the Public Health Service Act. (B) The term "Federally-qualified health center" means an entity which: (i) is receiving a grant under section 330 of the Public Health Service Act[282],

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act.

**Rural Health Clinic (RHC):** A Rural Health Clinic as defined under section 1905(I)(1) of the Social Security Act. A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement.

**FQHC Look-Alike:** An organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.

**Deputization:** The formal extension of VFC authority to provide VFC vaccines to eligible underinsured children from a participating FQHC or RHC to another VFC-enrolled provider. Under this arrangement, the deputizing FQHC or RHC retains its full scope of authority as a VFC provider while extending the authority to deputized VFC providers to immunize underinsured children with VFC vaccine.