DATE: 03/31/2026

TO: Parents of Rising 12th Grade Students

FROM: Gloucester Public Schools and Gloucester Health Department

SUBJECT: M**eningococcal Vaccination for 12th Graders**

State law requires all students entering the 12th grade receive a booster dose of Meningococcal ACWY vaccine. This means **all rising 12th graders must have received a dose of Meningococcal ACWY vaccine before they can start 12th grade. If your child has had a Meningococcal ACWY vaccine on or after the age of 16, they are only required to have one dose.**

If your child has already received their vaccination, please send a copy of the vaccination record to the school. If your child has not received this vaccination, and you would like him/her to be vaccinated at school, the Health Department will provide the required immunization at **Gloucester High School** on **April 16th** starting at 9 am **at no cost** to the student / family.

If your child has private insurance/FAMIS/Medicaid, enter the coverage information on the consent form as requested along with a copy of the front and back of your insurance card. VDH is required to bill for the service if you have medical coverage. Vaccine is limited and will be provided on a first come, first served basis.

Attached are two forms:

- 2026 Student Vaccination Consent Form (**complete front and back and return to the school**).
- Meningococcal ACWY Vaccine Information Statement (**read and keep**).

If your child is sick, he/she will not be able receive the vaccine. Ensure your child wears clothing that allows their arm to be easily accessible. In order for your child to be vaccinated at school, the **Vaccination Consent Forms must be filled out and returned to the school** as soon as possible, but no later than **April 13th.**

If you have any questions, please contact the school nurse.

2026 ADOLESCENT VACCINATION CONSENT FORM

(Tdap, HPV, Meningococcal ACWY)

VDH VIRGINIA DEPARTMENT OF HEALTH

Name: _____
Last First Middle

Date of Birth: ____/____/____ Age: _____ Gender: ❑ M ❑ F

If minor - parent/guardian's name: _____
Last First M.I.

Parent/Guardian's Date of Birth: __/____/____ Parent's SSN: _____
Optional

Address: _____ City: _____ ZIP: _____

Grade: _____ Home Room Teacher: _____ School: _____

IMPORTANT Parent/Guardian Phone # Home: _____ Cell: _____ Work: _____

Emergency Contact:_____ Emergency contact number:_____
(If other than Head of Household)

Health Department Use Only

Cli ID #: _____

Encounter #: _____

My child will be 11 years of age or older on the day of the scheduled vaccination clinic: YES □ NO □

Please check YES or NO to all the questions below to determine if your child can receive offered vaccines at school. The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO
Has your child ever had a serious allergic reaction to any vaccine component or yeast?	❑	❑
Has your child ever had a serious reaction to a previous dose of Tdap, HPV, or Meningococcal vaccine in the past?	❑	❑
Did your child experience a coma, decreased level of consciousness, or long or multiple seizures within seven days following a dose of DTP, DTaP or Tdap?	❑	❑
Does your child have seizures or another nervous system problem; ever had severe swelling or severe pain after a previous dose of DTP, DTaP, DT, or Td; or ever had Guillain-Barré Syndrome (GBS)? If so, consult your doctor about receiving Tdap vaccine. (A note may be required to proceed in school setting)	❑	❑
Is your child pregnant? If yes, your child will not receive the HPV vaccine, but may receive the other vaccines.	❑	❑

If you answered YES to questions, this vaccine(s) may not be safe for your child and s/he WILL NOT receive these vaccines at school. If your child has a severe life-threatening allergy, please speak with your child's doctor before consenting to vaccination.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:
1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. 2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

*** Insurance*:** Please answer the following: This information is required for federal funding purposes for VFC vaccines.

***Note**: Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program. If your child is covered by a private health insurance plan, the Department shall seek reimbursement for all allowable costs associated with the provision of the vaccine. **Your child will not be vaccinated if you do not provide all requested insurance information below.**

My child:( ) is *not* insured (not covered by private insurance, Medicaid, Medicaid MCO or FAMIS)
( ) is American Indian or is an Alaska Native
( ) has Medicaid MCO with: Sentara Community Care, Anthem Healthkeepers Plus, Molina Healthcare, United Healthcare Community Plan, or Aetna Better Health (circle your plan)
Member ID # as shown on your card: _____ is this a FAMIS plan? ❑Y ❑N
( ) has Medicaid or FAMIS (circle one) that is not a MCO plan: Medicaid # _____
( ) has other insurance not listed above (specify plan name) _____
Policy ID # _____ Policy holder's name_____
Attach a copy of the front & back of insurance card or provide the following information:
Insurance company address _____
Insurance company phone number _____

I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third-party payer to pay any authorized benefits to VDH on my behalf.

Office of Privacy and Security

Authorization for Disclosure of Protected Health Information

This consent gives the Virginia Department of Health (VDH) permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that immunization records of my child will be retained for 21 years after birth.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

❑ Please check box if you wish to receive a copy of the Virginia Department of Health Notice of Privacy Practices.

CONSENT FOR CHILD'S HPV VACCINATION:

☐ My child has NEVER been vaccinated for HPV. **Note: Your child will require two doses: the first dose now and the 2nd Dose 6 months after Dose 1. NOTE: children with certain medical conditions may require three doses. Please consult your provider to assess the need for a third dose.**

☐ My child has received the first dose of the HPV vaccine. **Note: the 2nd Dose should be received 6 months after Dose 1.**

I have read the 2021 Vaccination Information Statement (VIS) for the HPV Vaccine. I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the HPV vaccine (shot) **If needed, I give my consent for my child to receive the second dose approximately six months after the first dose.**

Signature of Parent or Legal Guardian: X _____Date: ____/_____/____

CONSENT FOR CHILD'S MenACWY VACCINATION:

I have read the 2025 Vaccination Information Statement (VIS) for the MenACWY Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Meningococcal ACWY vaccine (shot**).**

Signature of Parent or Legal Guardian: X _____Date: ____/_____/____

CONSENT FOR CHILD'S Tdap VACCINATION:

I have read the 2025 Vaccination Information Statement (VIS) for the Tdap Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Tdap vaccine (shot**).**

Signature of Parent or Legal Guardian: X _____Date: ____/_____/____

Please send a copy of my child's immunization record to her/his doctor at the following address.

*Doctor's Name*_____*Mailing Address*_____*City*_____ *State*_____*ZIP*_____

HEALTH DEPARTMENT USE ONLY					
Date	**Item code**	**Fund Source**	**Lot Number**	**Vaccine Administration Site**	**Provider #**
	Tdap-	**VFC STF**		**RA LA**	
	MCV4-	**VFC STF**		**RA LA**	
	HPV9 #1	**VFC STF**		**RA LA**	
	HPV9 #2	**VFC STF**		**RA LA**	
		VFC STF		**RA LA**	
Comments					
Provider Name/Signature and Date					

Meningococcal ACWY 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?

Meningococcal ACWY vaccine can help protect against **meningococcal disease** caused by serogroups A, C, W, and Y. A different meningococcal vaccine is available that can help protect against serogroup B.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

Meningococcal disease is rare and has declined in the United States since the 1990s. However, it is a severe disease with a significant risk of death or lasting disabilities in people who get it.

Anyone can get meningococcal disease. Certain people are at increased risk, including:

- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of *N. meningitidis*, the bacteria that cause meningococcal disease
- People at risk because of an outbreak in their community

2. Meningococcal ACWY vaccine

Adolescents need 2 doses of a meningococcal ACWY vaccine:

- First dose: 11 or 12 years of age
- Second (booster) dose: 16 years of age

In addition to routine vaccination for adolescents, meningococcal ACWY vaccine is also recommended for **certain groups of people**:

- People at risk because of a serogroup A, C, W, or Y meningococcal disease outbreak
- People with HIV
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called "complement component deficiency"
- Anyone taking a type of drug called a "complement inhibitor," such as eculizumab (also called "Soliris"®) or ravulizumab (also called "Ultomiris"®)
- Microbiologists who routinely work with isolates of *N. meningitidis*
- Anyone traveling to or living in a part of the world where meningococcal disease is common, such as parts of Africa
- College freshmen living in residence halls who have not been completely vaccinated with meningococcal ACWY vaccine
- U.S. military recruits

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

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

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

There is limited information on the risks of this vaccine for pregnant or breastfeeding women, but no safety concerns have been identified. A pregnant or breastfeeding woman should be vaccinated if indicated.

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 meningococcal ACWY vaccine.

Your health care provider can give you more information.

4. Risks of a vaccine reaction

- Redness or soreness where the shot is given can happen after meningococcal ACWY vaccination.
- A small percentage of people who receive meningococcal ACWY vaccine experience muscle pain, headache, or tiredness.

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 members 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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. 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.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- 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**.

DECLARACIÓN DE INFORMACIÓN DE LA VACUNA

Vacuna meningocócica ACWY:
Lo que necesita saber

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

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

1. ¿Por qué es necesario vacunarse?

La vacuna meningocócica ACWY ayuda a proteger contra **la enfermedad meningocócica** que causan los serogrupos A, C, W e Y. Está disponible otra vacuna meningocócica que ayuda a proteger contra el serogrupo B.

La enfermedad meningocócica puede causar meningitis (infección del revestimiento del cerebro y la médula espinal) e infecciones de la sangre. Incluso cuando se trata, la enfermedad meningocócica causa la muerte de 10 a 15 de cada 100 personas infectadas. Además, en quienes sobreviven, aproximadamente 10 a 20 de cada 100 personas quedan con discapacidades, como pérdida de la audición, daño cerebral, daño en los riñones, pérdida de miembros, problemas del sistema nervioso o cicatrices muy evidentes por injertos de piel.

La enfermedad meningocócica es infrecuente y ha disminuido en Estados Unidos desde la década de 1990. Sin embargo, es una enfermedad grave, con riesgo significativo de muerte o discapacidades duraderas en quienes la padecen.

Cualquier persona puede contraer la enfermedad meningocócica. Algunas personas tienen un mayor riesgo, incluidos:

- Bebés menores de un año
- Adolescentes y adultos jóvenes de 16 a 23 años
- Personas con ciertos trastornos médicos que afectan al sistema inmunitario
- Microbiólogos que trabajan habitualmente con aislados de *Neisseria meningitidis*, la bacteria que causa la enfermedad meningocócica
- Personas en riesgo a causa de un brote en su comunidad

2. Vacuna meningocócica ACWY

Los adolescentes necesitan 2 dosis de la vacuna meningocócica ACWY:

- Primera dosis: a los 11 o 12 años
- Segunda dosis (de refuerzo): a los 16 años

Además de la vacunación rutinaria de adolescentes, la vacuna meningocócica ACWY también se recomienda a **ciertos grupos de personas**:

- Personas en riesgo a causa de un brote de enfermedad meningocócica de los serogrupos A, C, W o Y
- Personas con el virus de la inmunodeficiencia humana
- Personas cuyo bazo sufrió daños o fue extirpado, incluidas las personas con enfermedad drepanocítica
- Todas las personas con un trastorno poco frecuente del sistema inmunitario, denominado "deficiencia de componentes del complemento"
- Cualquier persona que reciba un tipo de medicamento llamado "inhibidor del complemento", como el eculizumab (también llamado "Soliris"®) o ravulizumab (también llamado "Ultomiris"®)
- Microbiólogos que trabajan rutinariamente con aislados de *N. meningitidis*
- Toda persona que viaje a partes del mundo donde la enfermedad meningocócica sea frecuente, como en algunas partes de África, o viva en ellas
- Estudiantes universitarios de primer año que vivan en dormitorios y no se hayan vacunado por completo con la vacuna meningocócica ACWY
- Reclutas militares de EE. UU.

3. Hable con su proveedor de atención médica

Informe a su proveedor de vacunas si la persona que recibe la vacuna:

- Ha tenido una **reacción alérgica después de recibir una dosis previa de la vacuna meningocócica ACWY** o si ha tenido cualquier **alergia severa y potencialmente mortal**

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

En algunos casos, su proveedor de atención médica podría decidir que se posponga la vacunación meningocócica ACWY hasta una visita futura.

Hay poca información sobre los riesgos de esta vacuna en embarazadas o mujeres que amamantan, sin que se hayan identificado problemas de seguridad. Se debe vacunar a mujeres embarazadas o que amamantan si está indicado.

Se puede vacunar a personas con enfermedades leves, como el catarro común. Las personas con enfermedad moderada o grave usualmente deben esperar hasta recuperarse antes de recibir la vacuna meningocócica ACWY.

Su proveedor de atención médica puede proporcionarle más información.

4. Riesgos de una reacción a la vacuna

- Puede ocurrir enrojecimiento o dolor en el sitio de administración de la inyección después de recibir la vacuna meningocócica ACWY.
- Un pequeño porcentaje de personas que reciben la vacuna meningocócica ACWY experimenta dolor muscular, dolor de cabeza o cansancio.

En algunos casos, las personas se desmayan después de procedimientos médicos, incluidas las vacunaciones. Informe a su proveedor de atención médica si se siente mareado o si tiene cambios en la visión o zumbido en los oídos.

Al igual que con cualquier medicina, hay probabilidades muy remotas de que una vacuna cause una reacción alérgica grave, otra lesión grave o la muerte.

5. ¿Qué hago si ocurre algún problema grave?

Podría ocurrir una reacción alérgica después de que la persona vacunada deje la clínica. Si observa signos de una reacción alérgica grave (ronchas, hinchazón de la cara y garganta, dificultad para respirar, latidos rápidos, mareo o debilidad), llame al **9-1-1** y lleve a la persona al hospital más cercano.

Llame a su proveedor de atención médica si hay otros signos que le preocupan.

Las reacciones adversas se deben reportar al National Vaccine Adverse Event Reporting System, VAERS (Sistema para reportar reacciones adversas a las vacunas). Es usual que el proveedor de atención médica informe sobre ello, o también puede hacerlo usted mismo. Visite el sitio web de VAERS en **www.vaers.hhs.gov** o llame al **1-800-822-7967**. *El VAERS es solo para informar sobre reacciones y el personal de VAERS no proporciona consejos médicos.*

6. Programa nacional de compensación por lesiones ocasionadas por vacunas

El Vaccine Injury Compensation Program, VICP (Programa nacional de compensación por lesiones ocasionadas por vacunas) es un programa federal que se creó para compensar a las personas que podrían haber experimentado lesiones ocasionadas por ciertas vacunas. Las reclamaciones relativas a presuntas lesiones o fallecimientos debidos a la vacunación tienen un límite de tiempo para su presentación, que puede ser de tan solo dos años. Visite el sitio web de VICP en **www.hrsa.gov/vaccinecompensation** o llame al **1-800-338-2382** para obtener información acerca del programa y de cómo presentar una reclamación.

7. ¿Dónde puedo obtener más información?

- Consulte a su proveedor de atención médica.
- Llame a su departamento de salud local o estatal.
- Visite el sitio web de la Food and Drug Administration, FDA (Administración de Alimentos y Medicamentos), para consultar los folletos informativos de las vacunas e información adicional en **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Comuníquese con los Centers for Disease Control and Prevention, CDC (Centros para el Control y Prevención de Enfermedades):
  - Llame al **1-800-232-4636** (**1-800-CDC-INFO**) o
  - Visite el sitio web de los CDC en **www.cdc.gov/vaccines**.

Spanish translation provided by the Immunization Action Coalition