National Immunization Survey – Teen

Teen Immunization History Questionnaire

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

CDC
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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 ☐ Don't Know
  - Go to question 2 below.
- ☐ Other-Explain
- ☐ You have provided care to this adolescent, but do not have immunization records.
- ☐ You have no record of providing care to this adolescent.

Please complete items 5-9 and return form as instructed above.

2. According to your records, what is this adolescent's date of birth?

Month | Day | Year

☐ Don't know

3. What were the dates of this adolescent's first and most recent visit, for any reason, to this place of practice?

	Month	Day	Year	
First Visit				☐ Don't know
Most Recent Visit				☐ Don't know

4. Did this adolescent receive an 11-12 year old well child exam or check-up at this place?

☐ Yes ☐ No ☐ Don't know

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 ☐ No ☐ Don't know

5b. Which of the following describes this facility?

Check all that apply.

- ☐ Private practice (If yes, select ☐ Solo, ☐ Group, or ☐ Health Maintenance Organization (HMO))
- ☐ Hospital-based clinic, including university clinic, or residency teaching practice
- ☐ Public health department-operated clinic
- ☐ Community health center
- ☐ Rural Health Clinic
- ☐ Migrant health center
- ☐ Indian Health Service (IHS)-operated center, Tribal health facility, or urban Indian health care facility
- ☐ Military health care facility (Army, Navy, Air Force, Marines, Coast Guard)
- ☐ WIC clinic
- ☐ School-based health center
- ☐ Pharmacy
- ☐ Non-medical facility that hosted a vaccination clinic run by the health department or other sponsor
- ☐ Other-Explain

5c. Which of the following best describe the main specialties of this facility? *Check all that apply.*

- ☐ Pediatrics
- ☐ Family Practice
- ☐ General Practice
- ☐ Internal Medicine
- ☐ OB/GYN
- ☐ Other-Explain

6. Does 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)

7. Did you or your facility report any of this adolescent's immunizations to your community or state registry?

☐ Yes ☐ No ☐ Don't know

☐ Not applicable (No registry in my community/state)

☐ Not applicable (Practice does not administer vaccines)

8. Contact information for the person returning this form.

Name:

☐ Physician ☐ Nurse

☐ Office Manager/Receptionist ☐ Medical Records Administrator/Technician

☐ Other

Phone: ( ) ext.

Fax: ( ) ext.

9. 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		Date Given Month	Day	Year	Given by Other Practice?		Type of Vaccine (Mark one box for each vaccine dose received after age 6)		
Td/Tdap boosters received after age 6	1	11	18	2002	☐ Yes	☒ No	☐ Td	☐ Tdap (Adacel® or Boostrix®)	
	2				☐ Yes	☐ No	☐ Td	☐ Tdap (Adacel® or Boostrix®)	
	3				☐ Yes	☐ No	☐ Td	☐ Tdap (Adacel® or Boostrix®)	
MMR	1				☐ Yes	☐ No	☐ MMR	☐ MMR-Varicella	☐ Measles only
	2	9	20	2002	☒ Yes	☐ No	☐ MMR	☐ MMR-Varicella	☐ Measles only

- **Be sure to mark the "Yes" or "No" box under "Given by other practice?" for vaccinations given by another practice (see example above).**
- **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)**

		Month	Day	Year	Given by Other Practice?		Please enter a description of each vaccine dose
Other or additional doses of vaccines listed above	1	11	20	2001	☒ Yes	☐ No	TYPHOID
	2				☐ Yes	☐ No	

Please do not record Polio, Hib, or any Pneumococcal vaccine 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.

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Please record all vaccination dates in your records for these vaccine types. We realize you might not have the full immunization history of this adolescent.

Vaccine	Date Given (Month / Day / Year)	Given by Other Practice?	Type of Vaccine
Td/Tdap boosters received after age 6	1 / 2 / 3	Yes / No	*Mark one box for each vaccine dose received after age 6*: Td; Tdap (Adacel® or Boostrix®)
Hepatitis B received since birth	1 / 2 / 3 / 4	Yes / No	*Mark one box for each vaccine dose*: 0.5 ml Recombivax®; 1.0 ml Recombivax®; Engerix®; HepB only - unknown type; HepB-Hib
Seasonal Influenza received in the past three years	1 / 2 / 3	Yes / No	*Mark one box for each vaccine dose*: Inactivated Influenza Vaccine (IIV)[a]; Live Attenuated Influenza Vaccine (LAIV)[b]
MMR	1 / 2	Yes / No	*Mark one box for each vaccine dose*: MMR; MMR-Varicella; Measles only
Varicella	1 / 2	Yes / No	*Mark one box for each vaccine dose*: Varicella only; MMR-Varicella
Hepatitis A	1 / 2 / 3	Yes / No	*Mark one box for each vaccine dose*: HepA only (Havrix® or Vaqta®)
Meningococcal - serogroups ACWY	1 / 2	Yes / No	*Mark one box for each vaccine dose*: MCV4 or MenACWY (Menactra®, Menveo® or MenQuadfi®); MPSV4 (Menomune®); MenABCWY (Penbraya®)
Meningococcal - serogroup B	1 / 2 / 3	Yes / No	*Mark one box for each vaccine dose*: MenB-FHbp (Trumenba®); MenB-4C (Bexsero®); MenABCWY (Penbraya®)
Human papillomavirus (HPV)	1 / 2 / 3	Yes / No	*Mark one box for each vaccine dose*: Gardasil® (4vHPV); Gardasil® 9 (9vHPV); Cervarix® (2vHPV)
COVID-19 Vaccine	1 / 2 / 3 / 4	Yes / No	*Mark one box for each vaccine dose*: Pfizer-BioNTech®; Moderna®; Novavax®; OTHER → *Please specify brand*
Other or additional doses of vaccines listed above	1 / 2 / 3 / 4 / 5	Yes / No	*Please enter a description of each vaccine dose*

☐ *Child has a history of chickenpox*

Please remember to answer all questions on page 1.

Please do not record Polio, Hib, or any Pneumococcal vaccine given before 5 years old.

[a]Injected, eg. Fluzone®, Fluvirin®, Fluarix®, Afluria®, FluLaval®, Flucelvax® [b]Inhaled nasal flu spray, eg. FluMist®

If you need more space to report vaccines, please attach additional sheets.

For Office Use Only

Data Coll Period	Initial	Date
Progress		
MR or QX rcvd		
Trans complete		
Need Retrieval		
Retrieval Complete		
Edit Complete		
DE Vndr return		

Thank you!

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, please visit the CDC Vaccines & Immunization website at www.cdc.gov/vaccines.

If you would like more information about the National Immunization Survey, including data and statistics from previous years, please visit the National Immunization Survey website at http://www.cdc.gov/vaccines/NIS. If you have any questions or comments about this study, please call (800) 817 4316 or email nis@cdc.gov.

If you would prefer the study team to send immunization history requests via encrypted email, please reach out to us at NISProvider@norc.org.

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(l)(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(l)(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.