Bauxite School District
Flu Immunization Clinic
October 7, 2020

Dear Parent/Guardian,

We will be having a Flu immunization clinic on October 7, 2020. If you would like for your child to receive the Flu vaccine during this time, please review and complete the attached forms. Only those students with the required completed and **signed paperwork** will be allowed to receive the Flu vaccine. The completed forms need to be returned to the school on or before October 5, 2020. If you have any questions or concerns, please contact me or your local health department.

Thank you,

Elana Johnson BSN, RN

Bauxite School District Nurse

Fight the Flu in Arkansas

Dear Parent,

It is very important that you read this letter and follow through with the steps required so that your child can be protected from the flu.

This year, in partnership with the Arkansas Department of Health (ADH), school districts are holding Flu Immunization clinics in schools to provide flu vaccine for students.

For your child to receive the flu vaccine, you must:

1. Read the Vaccine Information Statement for the vaccine.
2. Read and complete the front and back of the Arkansas Department of Health (ADH) consent form.
3. PRINT clearly all information required on the ADH consent form.
4. Make sure you have signed the ADH consent form for the flu vaccine.
5. Sign the school district (FERPA) consent form (you may have signed this form at the beginning of the school year when your child was registered for school).
6. Return both consent forms to your child's school as quickly as possible.

This is a great opportunity for children to receive this vaccine with no charge to you. If you have insurance, ADH will ask your insurance company to pay for the cost of giving the vaccine. If you do not have insurance or your insurance does not pay for vaccines, there will still be no charge to you.

REMEMBER, only those students with the required completed paperwork (the signed ADH consent AND the school district FERPA consent) will be allowed to receive the flu vaccine.

If you should have any questions or concerns about the vaccines or the ADH consent form, please contact your local health unit.

Thank you.

VACCINE INFORMATION STATEMENT

A Vaccine Information Statement (VIS) is a document, produced by the Centers for Disease Control and Prevention (CDC), that informs vaccine recipients – or their parents or legal representatives – about the benefits and risks of a vaccine they are receiving.

- To view the VIS for the Live, Intranasal Influenza Vaccine (nasal spray), go to

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flulive.html. This link can be viewed and downloaded from your desktop, laptop, tablet, smartphone or other web-based electronic device.

- To view the VIS for the Inactivated Influenza Vaccine (shot), go to

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html. This link can be viewed and downloaded from your desktop, laptop, tablet, smartphone or other web-based electronic device.

- For a paper copy of either the nasal spray or the shot VIS, you can go to your nearest Arkansas Department of Health Local Health Unit and receive a copy. Please call 1-800-462-0599 to find out the closest health unit to you.

- Copies of the flu VIS will also be available at the school the day of the flu clinic.

For more information, contact the Arkansas Department of Health's Immunization Section at 1-800-574-4040. Thank you.

ADH, July 2020

ARKANSAS DEPARTMENT OF HEALTH
INFLUENZA SEASON -- IMMUNIZATION CONSENT FORM

For ADH use only ADH Clinic Code: __________ School LEA #:______________ Date Of Service: __________
School Name: ________________________________ School Grade: ________

Person Receiving Vaccine:

(Legal) First Name: ____________________________ **MI:** ___ **Last Name:** ____________________________

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

If YES and further guidance is needed, notify the Regional CDNS	*YES	NO	
Do you have a fever today? (If you have a fever on the day of the clinic it may prevent you from receiving the influenza vaccine.)			If any answer is YES, you may not be able to receive the flu vaccine.
Have you ever had a serious reaction to a previous dose of flu vaccine, such as difficulty breathing, swelling of eyes or lips, wheezing, or immediate nausea or vomiting? Do you have a severe allergy to any foods or medications? (i.e., gelatin, gentamicin or neomycin)			
Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
Are you younger than 2 years? ☐ Yes ☐ No Are you older than 49 years? ☐ Yes ☐ No			If any answer is YES, you can receive only the <u>injectable</u> flu vaccine (shot), not the intranasal flu vaccine (flu mist).
Are you pregnant?			
Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? For a child 2 through 4 years: Have you been told by a health care provider that your child had wheezing or asthma in the past 12 months?			
Are you on long-term aspirin or aspirin-containing therapy? Do you take aspirin every day? Have you received influenza antiviral medications within the last 48 hours? (Tamiflu, Relenza, Rapivab, Xofluza)			
Have you received any of these vaccines in the last 28 days? Measles, mumps, rubella (MMR) ☐ Yes ☐ No Varicella (chickenpox) ☐ Yes ☐ No Intranasal influenza vaccine (Flu Mist) ☐ Yes ☐ No			
Do you have a severely weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer, rheumatoid arthritis, Crohn's disease, psoriasis, or radiation treatments)?			
Do you have close contact with a person who needs care in a protected hospital environment (for example, someone who has recently had a bone marrow transplant)?			
For parents NOT attending flu clinic with their child: If you answered No to all of the above questions, your child may receive either the flu shot (injectable) or flu mist (nasal spray). Please mark your preference of vaccine type below. **If your preferred vaccine type is not available or marked, the nurse will give what is available unless you indicate otherwise.** ☐ **Flu Shot** ☐**Flu Mist** ☐ **No Preference** ☐ **Do not give if my preference is not available** **Child's Homeroom Teacher:** ____________________**(For school clinic use)**			
• NOTE: Children aged 6 months through 8 years may require a second dose. Contact your health care provider or your ADH Local Health Unit in four weeks for more information.			

2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Arkansas Department of Health's Privacy Notice is on the website <u>www.healthy.arkansas.gov</u>, posted and available at the clinic site, or accompanies this form.
Then sign in the box at right.

Please sign here

My signature below indicates I have read, understand and agree to section **2. Release and Assignment** of the Influenza Season -- Immunization Consent Form. and **Vaccine Information Statement (VIS).**

Signature of Patient/Parent/Guardian:

______________________ date__________

RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine and the Live Attenuated Intranasal Vaccine (Flu Mist) and understand the risks and benefits. To read the Vaccine Information Statement (VIS) for each vaccine visit the website to view current VIS: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html**
- **I give consent to the State/Local Health Department and its staff for the individual named below to be vaccinated with the flu vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Arkansas Department of Health's Privacy Notice.**
- **I understand that information about this flu vaccination will be included in the Arkansas Department of Health's Immunization Registry.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to the Arkansas Department of Health.**
- **I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.**
- **I agree that the photocopy of this form may be used instead of the original.**

3. PATIENT INFORMATION:

(Legal) First Name: ______________________ **MI:** ____ **Last Name:** ______________________

Date of Birth: ☐☐/☐☐/☐☐☐☐ **Gender:** ☐ Male ☐ Female **Phone #:** ____________________

Street Address: ____________________________________ **P.O. Box** __________ **Apt. No.** __________

City: ______________________________ **State:** __________ **Zip Code:** ☐☐☐☐☐

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African-American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

4. INSURANCE STATUS (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

☐ **Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Insurance Company Name:** ____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER Information:

(Legal) First Name: ______________________ **MI:** ____ **Last Name:** ______________________

Policy Holder Date of Birth: ☐☐ /☐☐ /☐☐☐☐ **Email Address:** ______________________

Policy Holder's Employer Name: ____

Flu Vaccine Administration (Completed by ADH staff only)

SHOT CODE:

☐ 70: Quadrivalent (P-F) $\geq$ 6 months ☐ 39: Quadrivalent Intranasal vaccine (P-F) 2 - 49 years

	Route	Site Code	Dosage mL.	MFG Code	Lot Number
Flu Vaccine	☐ IM ☐ Intranasal				

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

MFG Codes: SKB = GlaxoSmithKline, PMC = Sanofi, MED = MedImmune, SEQ = Seqirus

Signature and Title of Vaccine Administrator: ________________________________

Date Vaccine Administered: ________/________/________