It’s that time of year to get a flu vaccine!

Attention Parents/Guardians:

Once again it’s time to register your child for the Flu vaccine. This year we will again be providing the Flu shot instead of FluMist. There have not been any safety concerns with The FluMist vaccine; however, the CDC recommended FluMist not be used this season due to lower effectiveness (especially the H1N1 strain).

It is very important to receive a flu vaccine this season as it is the best way to protect yourself from the flu.

PLEASE NOTE: Parents are welcome to be present, and vaccinated, when their child receives their flu shot. Clinic staff will stabilize your child’s arm; but will not restrain your child. Uncooperative or combative children will not be vaccinated. You will be notified if you authorized your child’s vaccination and your child did not get vaccinated at the school located flu clinic.

*All students will be offered the Flu shot vaccine at NO COST TO THEIR FAMILIES! However, if your child has health insurance, we are required to collect that information and bill the company for the vaccine. There will be no co-pay or deductible due. Children without insurance will receive the vaccine for free through the Vaccines for Children program. Your child's health insurance status will stay confidential.

Take advantage of this program by:

- **Reading** the Vaccine Information Statement and the Notice of Privacy Practices
- **AND**
- **Filling out** the consent form, attached, and returning it to your child's school.

**Consent Form is due August 25, 2017**

Clinics will begin in Sept, your school will let you know when your child will be receiving the Flu shot.

Staff will review your child's form to determine if s/he can receive the Flu shot. You will be contacted if your child is ineligible to receive the shot.

**VACCINATING CHILDREN CAN PROTECT THEM FROM FLU ALL YEAR**

- Vaccinating school children can stop the spread of flu infections, creating “Community Immunity.”
- The best way to prevent the flu is to get a flu vaccine every year.
- The Flu shot vaccine protects against four different types of flu.

**THE CONSENT FORM MUST BE RETURNED TO YOUR CHILD’S SCHOOL BY FRI. Aug. 25.**

Please, complete the consent form even if you do not want your child to participate! For more information, visit our website at Controlflu.com or contact the Health Department at (352) 334-7916.
### 2017-2018 Seasonal Flu Vaccine Consent Form

**THIS FORM MUST BE RETURNED**

Please complete the information below (unreadable and incomplete forms may not be accepted).

**This season, control flu will be vaccinating with the flu shot**

<table>
<thead>
<tr>
<th>Full, Legal Name of Student (First Name Middle Initial. Last Name)</th>
<th>Name of School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Name (First Name Middle Initial. Last Name)</td>
<td>Relationship to Student</td>
</tr>
<tr>
<td>Homeroom Teacher</td>
<td>Grade</td>
</tr>
<tr>
<td>Street Address</td>
<td>Email Address</td>
</tr>
<tr>
<td>Birth Date (month/date/year)</td>
<td>Age Sex</td>
</tr>
<tr>
<td>City:</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Home Phone #</td>
<td>Cell Phone #</td>
</tr>
</tbody>
</table>

Demographic Information: (Circle one) White American Indian/Native Alaskan Black Asian Hispanic Other

- [ ] INSURANCE
- [ ] MEDICAID (Prestige, UHC Community, StayWell/Wellcare, & Sunshine)
- [ ] MY CHILD DOES NOT HAVE HEALTH INSURANCE

The current health care laws require us to bill your insurance company for the vaccine. You will not be billed, and there will be no co-pay or deductible due. The service is offered at no cost to you! As always, answers are confidential. Please fill out the following questions regarding your child's health insurance plan:

- Insurance Company:
- Policy Holder's Name:
- Policy Holder's Date of Birth:

**HEALTH QUESTION: (If you answer YES, your child cannot receive a Flu shot unless approved by your child’s health care provider)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1. Do any of the following apply to your child?</td>
<td></td>
</tr>
<tr>
<td>☐ Severe allergy to chicken eggs or egg products</td>
<td></td>
</tr>
<tr>
<td>☐ Life threatening reaction(s) to flu vaccine in the past</td>
<td></td>
</tr>
<tr>
<td>☐ Has had Guillain-Barre syndrome (very rare)</td>
<td></td>
</tr>
</tbody>
</table>

**IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S HEALTH CARE PROVIDER OR CALL THE ALACHUA COUNTY HEALTH DEPARTMENT IMMUNIZATION CLINIC AT 352-334-7950.**

If your child has any long-term health problems with weakened immune system, heart disease, lung disease (e.g. cystic fibrosis), liver disease, kidney disease, or metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle disease or thalassemia), please see your health care provider for a flu vaccine.

I have received, read, and understand the CDC Vaccine Information Statement for the inactivated influenza (shot) vaccine and the Notice of Privacy Practices. I have read these documents and understand the risk and benefits of the Flu vaccine. I give permission to the State of Florida, Department of Health to give my child the first and second dose (if needed) of the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Florida Department of Health policies, to assure optimal healthcare for my child.

- [ ] YES, I Want to Protect My Child, Family and Community from Flu by allowing my Child to receive the Flu Shot!
- [ ] NO, I do not want my child to receive the flu shot vaccine at school, because

(Optional)

Printed Name of Parent/Guardian: ___________________________  Signature of Parent/Guardian: ___________________________

Date: ___________________________

**AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION**

<table>
<thead>
<tr>
<th>1st dose VIS: 08/07/2015</th>
<th>2nd dose VIS: 08/07/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Vaccine Lot # &amp; Expiration Date Label</td>
<td>2nd Vaccine Lot # &amp; Expiration Date Label</td>
</tr>
</tbody>
</table>

Date Given: ___________________________

Signature/Title: ___________________________  Signature/Title: ___________________________

Notes: ___________________________
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION
Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone numbers, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care ClearHealth Now.
The Department of Health can set as one of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the course of hospital care to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, healthcare providers, or community agencies to pay for the services provided to you.

Your information may be used by certain department personnel to improve the department’s health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services. Some protected health information can be disclosed without your written authorization as allowed by law. These circumstances include:

• Reporting abuse of children, adults, or disabled persons.
• Internal investigations related to a missing child.
• Law enforcement purposes.
• Judicial investigations.
• Court orders, warrants, or subpoenas.
• Law enforcement purposes.
• Administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and certain uses and disclosures of psychotherapy notes, and the sale of protected health information resulting in remuneration to the Department of Health.

INDIVIDUAL RIGHTS
You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You also may limit disclosures to individuals involved with your care. The department is not required to agree to any restriction. However, in situations where you or someone on your behalf pays for an item or service in full, and you request information concerning said item or service not be disclosed to an insurer, the Department will agree to the requested restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you. You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

• Was not created by the department.
• Is not part of the department’s protected health information.

Inaccurate and incomplete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

• Disclosures made to you.
• Disclosures to individuals involved with your care.
• Disclosures to health plans.
• Disclosures made to carry out treatment, payment, and health care operations.
• Disclosures for public health.
• Disclosures to health professional regulatory purposes.
• Disclosures to report abuse of children, adults, or disabled.
• Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

• Purposes of research, other than those you authorized in writing.
• Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than six years from the date of your request.

If you receive this Notice of Privacy Practices electronically, you have the right to a paper copy upon request. The Department of Health may mail or call you with health care appointment reminders.

DEPARTMENT OF HEALTH DUTIES
The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department’s legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of this Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of this notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email and at all Department of Health buildings. Also available are additional documents further explaining your rights to inspect and copy and amend your protected health information.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the: Department of Health’s Inspector General at 4053 Bald Cypress Way, Riverview, FL 33569-1974 (telephone 850-245-1411) and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 telephone 202-615-0277 or toll free 877-696-6774.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION
Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health’s Inspector General at 4053 Bald Cypress Way, Riverview, FL 33569-1974 (telephone 850-245-1411).

EFFECTIVE DATE
This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES
1 Why get vaccinated?

Influenza (Flu) is a contagious disease that spreads throughout the United States every year, usually between October and May. Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get the flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- Fever/chills
- Sore throat
- Muscle aches
- Fatigue
- Cough
- Headache
- Runny or stuffy nose
- Vomiting

Flu can also lead to pneumonia and other serious infections, and cause hospital stays in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people, including children, infants, and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system at increased risk.

Each year thousands of people in the United States die from flu, and many more are hospitalized.

Flu vaccine can:

- Protect you from getting the flu.
- Make the flu less severe.
- Keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of the flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. People also need a new shot each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- If you have a severe, life-threatening allergy. If you ever had a life-threatening allergic reaction after a dose of the vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of the vaccine contain a small amount of egg protein.
- If you ever had Guillain-Barré Syndrome (also called GBS). People with a history of GBS should not get this flu vaccine. This should be discussed with your doctor.
- If you are not feeling well.
- If you have had the flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems follow a flu shot include:

- Swollen, tender, or red area where the shot was given
- Headache
- Sore red or itchy eyes
- Cough
- Fever
- Arthritis
- Rash
- Nausea
- Fatigue

If these problems occur, they usually begin soon after the shot and last for 2 days.

More serious problems following a flu shot can include:

- There may be a minor increase in risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated to be 1 in 10 million doses per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- You may experience fever.
- Young children may experience fever.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. If you do faint:
  - Lie down and raise your legs, and have someone call for help if you need it.
- Some people get a mild fever.

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

Signs of a severe allergic reaction may include:

- Swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These usually start a few minutes to 2 hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or another emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Report the reaction to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file a report, or you can do it yourself through the VAERS website at www.vaers.hhs.gov, or by calling 1-800-822-7977.

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 vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- 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/fluv

Vaccine Information Statement

Inactivated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26