

FluMist is Safe, Effective and Free*!

Attention Parents/Guardians: **Flu Mist is Back!**

Once again it's time to register your child for FluMist. FluMist is an influenza vaccine that is a gentle mist sprayed into the nose. It's a safe and effective way of preventing the flu in your child and in the rest of your family.



*All students will be offered the FluMist nasal spray 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
AND
- **Filling out** the consent form, attached, and returning it to your child's school, fax to (352) 334-7947, or EMAIL it to; SLIV@flhealth.gov
(Please note that e-mailing may not be a secure method of communication)

At P.K. Yonge, Consent Forms are due by Monday, October 1, 2018

The P.K. Yonge Flu Mist Clinic is on Friday, October 12, 2018

Staff will review your child's form to determine if s/he can receive FluMist. You will be contacted if your child is ineligible to receive the mist. If your child cannot get FluMist, we strongly recommend you arrange for a flu shot as soon as possible.

VACCINATING CHILDREN CAN PROTECT THEM AND YOUR FAMILY 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 FluMist vaccine protects against four different types of flu.

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.



2018-2019 Seasonal FluMist Vaccine Consent Form

Please Return this Form to P.K. Yonge by Oct 1st, 2018

PLEASE COMPLETE THE INFORMATION BELOW (Unreadable and incomplete forms may not be accepted.)

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

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/Medicaid Plan	Member ID:
Policy Holder's Name:	Policy Holder's Date of Birth:

HEALTH QUESTIONS: CHECK YES OR NO FOR EACH QUESTION

Yes	No	<p>1. Do any of the following apply to your child? <i>(If you answer YES, your child cannot receive FluMist unless approved by your child's doctor)</i></p> <ul style="list-style-type: none"> • Allergy to gelatin, chicken eggs or egg products • Life threatening reaction(s) to flu vaccine in the past • Currently receiving aspirin or aspirin-containing therapy • Currently has active asthma (regularly taking asthma medication) • Has had Guillain-Barre syndrome (very rare) • Is pregnant or nursing/breastfeeding • Has HIV/AIDS or cancer or has received an organ transplant • Has 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) • Has other severe chronic health conditions
<input type="checkbox"/>	<input type="checkbox"/>	2. Will your child have close contact with a person with a severely weakened immune system? <i>(For example, a protective sterile hospital environment for bone marrow transplant)</i>
<input type="checkbox"/>	<input type="checkbox"/>	3. Between Aug. and Dec. 2018, has/will your child receive one of the following vaccines: MMR, MMRV, and/or Chicken pox vaccine (VZV)?
<p>IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S HEALTH CARE PROVIDER OR CALL THE ALACHUA COUNTY HEALTH DEPARTMENT TO SPEAK WITH A NURSE AT; 352-334-7950</p>		

I have received, read, and understand the CDC Vaccine Information Statement for the live attenuated intranasal flu vaccine (FluMist) and the Notice of Privacy Practices. I have read these documents and understand the risk and benefits of the FluMist 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 Help Protect My Child, Family And Community From Flu By Allowing My Child To Receive FluMist!

NO, I do not want my child to receive the FluMist Vaccine at school, because _____
(Optional)

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____

Date _____

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

<p>1st dose MedImmune (MED) FluMist, Intranasal (NAS), 0.2ml VIS: 08/07/2015</p> <p>Date Given: _____</p> <p>Signature/Title _____</p>	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <p>1st Vaccine Lot # & Expiration Date Label</p> </div>	<p>2nd dose MedImmune (MED) FluMist, Intranasal (NAS), 0.2ml VIS: 08/07/2015</p> <p>Date Given: _____</p> <p>Signature/Title _____</p>	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <p>2nd Vaccine Lot # & Expiration Date Label</p> </div>
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Notes:

**Please return to the school, FAX to (352) 334-7947, or EMAIL to; SLIV@flhealth.gov
(Please note that e-mailing may not be a secure method of communication)**

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.

P L E A S E R E A D C A R E F U L L Y



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. 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 the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its 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.



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 number, 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 clearinghouse. The Department of Health can act as each 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 clinics or hospital 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, Medicaid, 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. Those circumstances include:

- £ Reporting abuse of children, adults, or disabled persons.
- £ Investigations related to a missing child.
- £ Internal investigations and audits by the department's divisions, bureaus, and offices.

- £ Investigations and audits by the state's Inspector General and Auditor General and the legislature's Office of Program Policy Analysis and Government Accountability.
- £ Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
- £ District medical examiner investigations.
- £ Research approved by the department.
- £ 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 for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.



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 may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health may mail or call you with health care appointment reminders. We 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 protected health information,
- £ Is by law not available for your inspection, or
- £ Is accurate and complete.

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 authorized by you.
- £ Disclosures made to carry out treatment, payment, and health care operations.
- £ Disclosures for public health.
- £ Disclosures for 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 a 6-year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

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, Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/telephone 850-245-4141.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 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 202-619-0257 or toll free 877-696-6775. 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.

Effective Date

This Notice of Privacy Practices is effective beginning April 14, 2003, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

References

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register*, Vol. 65, No. 250 (December 28, 2000).

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register*, Vol. 67, No. 157 (August 14, 2002).

DH 150-741, 4/03; Stock Number: 5730-741-0150-0

Influenza (Flu) Vaccine (Live, Intranasal): 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?

Influenza (“flu”) is a contagious disease that spreads around 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 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

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures 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. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

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

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Live, attenuated flu vaccine—LAIV, Nasal Spray

A dose of flu vaccine is recommended every flu season. Children younger than 9 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

The **live, attenuated influenza vaccine** (called LAIV) may be given to healthy, non-pregnant people **2 through 49 years of age**. It may safely be given at the same time as other vaccines.

LAIV is sprayed into the nose. LAIV does not contain thimerosal or other preservatives. It is made from weakened flu virus and **does not cause flu**.

There are many flu viruses, and they are always changing. Each year LAIV is made to protect against four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn’t exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Some people should not get LAIV because of age, health conditions, or other reasons. Most of these people should get an injected flu vaccine instead. Your healthcare provider can help you decide.

Tell the provider if you or the person being vaccinated:

- have any allergies, including an allergy to eggs, or have ever had an allergic reaction to an influenza vaccine.
- have ever had Guillain-Barré Syndrome (also called GBS).
- have any long-term heart, breathing, kidney, liver, or nervous system problems.
- have asthma or breathing problems, or are a child who has had wheezing episodes.
- are pregnant.
- are a child or adolescent who is receiving aspirin or aspirin-containing products.
- have a weakened immune system.
- will be visiting or taking care of someone, within the next 7 days, who requires a protected environment (for example, following a bone marrow transplant)



Sometimes LAIV should be delayed. Tell the provider if you or the person being vaccinated:

- are not feeling well. The vaccine could be delayed until you feel better.
- have gotten any other vaccines in the past 4 weeks. *Live* vaccines given too close together might not work as well.
- have taken influenza antiviral medication in the past 48 hours.
- have a very stuffy nose.

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 LAIV do not have any problems with it. Reactions to LAIV may resemble a very mild case of flu.

Problems that have been reported following LAIV:

Children and adolescents 2-17 years of age:

- runny nose/nasal congestion
- cough
- fever
- headache and muscle aches
- wheezing
- abdominal pain, vomiting, or diarrhea

Adults 18-49 years of age:

- runny nose/nasal congestion
- sore throat
- cough
- chills
- tiredness/weakness
- headache

Problems that could happen after any vaccine:

- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very small chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

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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 can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling **1-800-822-7967**.

VAERS does 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.

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/flu

Vaccine Information Statement
Live Attenuated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26

Office Use Only

