Flu Mist is Safe, Effective and Free*!

Attention Parents/Guardians:

Once again, it’s time to register your child for Flu Mist. Flu Mist 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 Flu Mist 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, within 14 days of receipt.

  *(Please note that e-mailing may not be a secure method of communication)*

Home schooled and Virtual learning children may also receive the FluMist at the school on the scheduled date.

Your school will let you know when your child will be receiving FluMist.

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.
2022-2023 Seasonal Flu Mist Vaccine Consent Form

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

<table>
<thead>
<tr>
<th>Full, Legal Name of Student (First Name Middle Initial. Last Name) PLEASE PRINT</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>Street Address</td>
<td>Email Address</td>
</tr>
<tr>
<td>City:</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Demographic Information: (Circle one)</td>
<td>While</td>
</tr>
<tr>
<td>INSURANCE</td>
<td>MEDICAID (Prestige, UHC Community, StayWell/Wellcare &amp; Sunshine)</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Insurance Company/Medicaid Plan</th>
<th>Member ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder’s Name</td>
<td>Policy Holder’s Date of Birth</td>
</tr>
</tbody>
</table>

**HEALTH QUESTIONS: CHECK YES OR NO FOR EACH QUESTION**

Yes | No
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1. Do any of the following apply to your child? *If you answer YES, your child cannot receive FluMist unless approved by your child’s doctor*
- 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 cell disease or thalassemia)
- Has other severe chronic health conditions

2. Will your child have close contact with a person with a severely weakened immune system? *(For example, a protective sterile hospital environment for bone marrow transplant)*

3. Between July, 2022, and Dec. 2022, has/will your child receive one of the following vaccines: MMR, MMRV, and/or Chicken pox vaccine (VZV)?

**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**

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 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

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**Printed Name of Parent/Guardian**

**Signature of Parent/Guardian**

**Date**

**AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION**

- MedImmune (MED)
- FluMist, Intranasal (NAS), 0.2ml
- VIS: 08/6/2021
- Date Given:
- Signature/Title:

**Vaccine Lot #: & Expiration Date Label**

**Nurse/clinic notes:**

Notes:

Please return to the school, FAX to (352) 334-7947, or EMAIL to; SLIV@fhealth.gov

(Please note that e-mailing may not be a secure method of communication)
**NOTICE OF PRIVACY PRACTICES**

NOW YOU CAN GET ACCESS TO THIS INFORMATION ABOUT YOUR USE AND DISCLOSED AS:

**PHASE REVIEW OF CURRICULUM**

The Notice of Privacy Practices is a document that outlines how an organization, such as a healthcare provider, handles and protects the privacy of your personal health information. The notice is required to be provided to all patients, and it is considered a legal requirement by the Health Insurance Portability and Accountability Act (HIPAA). The notice explains how your personal health information will be used and disclosed, and it outlines your rights and responsibilities regarding your health information.

**CONTENTS**: The Notice of Privacy Practices typically includes the following sections:

1. **INTRODUCTION**: Provides an overview of the notice and the purpose of the notice.
2. **HISTORY OF NOTICE OF PRIVACY PRACTICES**: Describes the origin and evolution of the notice.
3. **WHO WE ARE**: Identifies the entity or organization that is responsible for maintaining the privacy of your personal health information.
4. **WHAT INFORMATION WE COLLECT**: Describes the types of personal health information we collect and how it is collected.
5. **HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION**: Explains how we use and disclose your personal health information for treatment, payment, and operations.
6. **WHO WE SHARE YOUR INFORMATION WITH**: Outlines the types of persons or entities to whom we disclose your personal health information.
7. **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**: Describes your rights to access, amend, restrict, and request an accounting of disclosures.
8. **HOW TO COMPLAIN**: Explains how you can file a complaint if you believe your privacy rights have been violated.

**ADDITIONAL INFORMATION**: The Notice of Privacy Practices may also include additional information, such as the names and contact information of individuals responsible for maintaining the privacy of your personal health information.