Dear Parents/ Guardians:

We are delighted to inform you about the vaccination collaboration between The Pulaski County Health Department (PCHD) and Pulaski County Public Schools. Immunization rates have dropped in our country and in Pulaski County. We often hear that parents find it difficult to arrange for children to receive immunizations with a physician or local health department. Because we believe in prevention and community service, we will offer the influenza (Flu) vaccine to all our students this year. Immunizations will be given on October 19th, 20th, 21th, and 25th.

"Flu" is a contagious respiratory illness caused by influenza viruses that infect the nose, throat and lungs. It is spread mainly from person to person by droplets that are released in the air when an infected person coughs or sneezes.

There will be no charge to parents of children who choose to receive the flu vaccine; however, Pulaski Health Department will collect your insurance information and bill for the cost of the vaccine. Any cost not covered by your insurance will not be billed to parents.

In order to provide vaccination to your child, you will need to **complete, sign, and return** the attached Student Flu Vaccination Consent form **to your child's school nurse by September 29, 2016.** Please **complete and sign the Consent Form.** In addition, you will want to read the *Influenza (flu) Vaccine Information Statement.* If a completed and signed consent form is not returned to the school, your child will not be given the vaccination.

You are under no obligation to participate. This is simply a service to parents of our students to alleviate the hardship associated with trying to schedule a doctor's visit, securing transportation, and potentially missing work in order to get your child's flu vaccination. When more people get vaccinated against the flu, less flu illness can spread throughout our community.

Please remember that your child does not have to participate in this vaccination opportunity and it does not eliminate the need for your child to receive regular check-ups with your health care provider.

Sincerely,

Kevin W. Siers, Ed.D.
Division Superintendent

2016-17 STUDENT INFLUENZA VACCINATION CONSENT FORM
INACTIVATED INFLUENZA (IIV) ONLY

Health Department Use Only
CI #:
Encounter #:
Receipt #:

Name: ______________________ ______________________ ______________
Last First Middle

Date of Birth: ____/____/____ Age: ____ Gender: ☐ M ☐ F

If minor - parent/guardian's name: ______________________ ______________________ ______
Last First M.I.

Parent/Guardian's Date of Birth: ____/____/____ Parent's SSN: ______ - ____ - ________
optional

Address: ______________________ City/State: ______________ ZIP: __________

Grade: ______ Home Room Teacher: ______________________ School: ______________

IMPORTANT Parent/Guardian Phone # Home: ______________ Cell: ______________ Work: ______________

Please check YES or NO to all of the questions below to determine if your child can receive the Inactivated Influenza Vaccine ("flu shot"). The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO
1. Has your child ever had a serious allergic reaction to any component of any flu vaccine (eggs, gentamicin, gelatin and arginine)?	☐	☐
2. Has your child ever had a serious reaction to a previous dose of flu vaccine in the past?	☐	☐
3. Has your child ever had Guillain-Barré syndrome (GBS, i.e., progressive ascending paralysis)?	☐	☐

If you answered YES to any of questions 1, 2 or 3 above about serious allergy, reaction or GBS, flu vaccine may not be safe for your child and s/he WILL NOT receive a flu vaccine.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:
1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. 2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

CONSENT FOR CHILD'S VACCINATION: In October 2016, <u>will your child be less than 9 years of age</u>? No ☐ Yes ☐
Please complete the next set of questions and sign.

My child is **under 9 years of age** and:

☐ has NEVER been vaccinated against the flu. **Note: Your child will require 2 doses this year.**

☐ has not been vaccinated with at least 2 doses of seasonal influenza vaccine before July 1, 2016. **Note: Your child will require 2 doses this year**

I have read the 2016 Vaccination Information Statement (VIS) for the Inactivated Influenza Vaccine (flu shot), I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the inactivated injectable influenza vaccine (shot). **If needed, I give my consent for my child to receive the second dose approximately 4 weeks after the first.**

Signature of Parent or Legal Guardian: X ______________________________ **Date:** ____/____/____

Turn to Back of Form

Insurance*: Please answer the following: This information is required for federal funding purposes for VFC vaccines.

*Note: Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program. If your child is covered by a private health insurance plan, the Department is required by law to seek reimbursement for all allowable costs associated with the provision of the vaccine.

My child: ( ) is *not* insured (by private insurance, Medicaid, or FAMIS)
( ) is American Indian or is an Alaska Native
( ) has Medicaid - Medicaid #: ____________________________
( ) has FAMIS - FAMIS #: ______________________
( ) has other insurance not listed above (specify plan) ____________________________
Policy ID # __________________________ Policy holder's name ______________________

Attach a copy of the front & back of insurance card or provide the following information:
Insurance company address ____
Insurance company phone number ______________________________

Office of Privacy and Security

Authorization for Disclosure of Protected Health Information

This consent gives the Virginia Department of Health (VDH) permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that this record will be retained until my child reaches 21 years of age.
- I authorize VDH release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. The third party payer to pay any authorized benefits to VDH on my behalf.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

☐ Please check box if you wish to receive a copy of the Virginia Department of Health Privacy Rights.

Please send a copy of my child's immunization record to her/his doctor at the following address.

Doctor's Name ______________________________

Mailing Address ______________________________ *City* __________________ *State* _________ *ZIP* ____________

HEALTH DEPARTMENT USE ONLY

Date	Item code	Cost type	Lot Number	Vaccine Administration Site	Provider #
		VFC Chargeable		RA LA	
		VFC Chargeable		RA LA	
Comments					
Provider Name/Signature and Date					

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *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 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose 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.

There is no live flu virus in flu shots. **They cannot cause the flu.**

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or 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

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.**
  If you ever had a life-threatening allergic reaction after a dose of flu 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 flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome (also called GBS).**
  Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.**
  It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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 following a flu shot include:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:

- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- 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 remote 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/**

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 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

Inactivated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26

Office Use Only