

## IMMUNIZATION CLINIC

9/30/2020

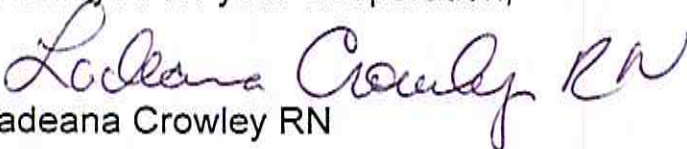
Dear Parent/Guardian,

In Collaboration with the Carter County Health Center, East Carter R2 Health Office will be offering FREE flu vaccination to all students on Tuesday, October 7<sup>th</sup>.

Enclosed is a vaccine information Statement to assist you in making your decision. Please read the information, if you decide you want your child to receive the Influenza Vaccine:

1. Fill out the consent form FRONT and BACK.
2. Parent or Legal Guardian must sign.
3. Return to the health office by Tuesday , October 6<sup>th</sup> 2020

Thank you for your Cooperation,

  
Ladeana Crowley RN  
Health Coordinator  
573-322-5325 ext.7

## 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](http://www.immunize.org/vis)

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://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/](http://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](http://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](http://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](http://www.cdc.gov/flu)

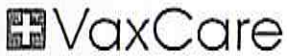
Vaccine Information Statement  
Inactivated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26

Office Use Only





# Parent Consent for \_\_\_\_\_ HD Vaccination Clinic

Partner ID:  Partner Name:   
 Clinic ID:  School Name:   
 Patient ID:  East Carter R-II

Consent ID: \_\_\_\_\_

VaxCare has partnered with your healthcare provider to provide immunizations.  
 All bills for privately insured patients will come from VaxCare and its physicians.

## ① School and Student Information

STUDENT FIRST NAME  MI  STUDENT LAST NAME  AGE  GRADE  GENDER:  M  F  
 DATE OF BIRTH (MM-DD-YYYY)  SCHOOL NAME  HOME ROOM TEACHER   
 ETHNICITY:  Amer. Indian / Alsk. Native  Asian  Black / Afr. Amer.  Hawaiian / Pac. Isld.  Hispanic  White  Other \_\_\_\_\_  
 STREET ADDRESS  APT/SUITE  CITY  STATE  ZIP   
 PARENT/GUARDIAN FIRST NAME  PARENT/GUARDIAN LAST NAME  PARENT/GUARDIAN PHONE

## ② Insurance Information (Please fill out completely!)

INSURANCE PAY Please fill in the circle to the left of your primary insurance name.

<input type="radio"/> AARP Secure Horiz	<input type="radio"/> Buckeye Comm Hlth Pln (age 19+)	<input type="radio"/> GEHA	<input type="radio"/> Medicare B	<input type="radio"/> Ohio HealthSpan
<input type="radio"/> Advantra	<input type="radio"/> CareSource (age 19+)	<input type="radio"/> Golden Rule	<input type="radio"/> Medicare Railroad	<input type="radio"/> The Health Plan
<input type="radio"/> Aetna	<input type="radio"/> CIGNA	<input type="radio"/> Great West-CIGNA	<input type="radio"/> Medigold	<input type="radio"/> Three Rivers
<input type="radio"/> All Savers	<input type="radio"/> CoreSource	<input type="radio"/> Humana	<input type="radio"/> Multiplan	<input type="radio"/> UMR
<input type="radio"/> Anthem/BCBS	<input type="radio"/> Coventry	<input type="radio"/> Mail Handlers Amer	<input type="radio"/> Ohio Health Choice	<input type="radio"/> UMWA
<input type="radio"/> BCBS Federal	<input type="radio"/> First Health	<input type="radio"/> Medical Mutual OH	<input type="radio"/> Ohio HealthSmart	<input type="radio"/> United Healthcare

PRIMARY INSURANCE NAME  MEMBER / INSURED ID#  GROUP ID

RELATIONSHIP TO THE SUBSCRIBER/INSURED:  Self  Spouse  Dependent  
 SUBSCRIBER/INSURED FIRST NAME  SUBSCRIBER/INSURED LAST NAME  SUBSCRIBER/INSURED DOB (MM-DD-YYYY)  GENDER:  M  F

By signing below, I consent to the use and disclosure of my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to VaxCare for the services rendered. I understand I will be responsible for payment for the vaccines provided if my insurance company does not pay.

MEDICAID STATE ID #   NO INSURANCE I have no insurance or Medicaid coverage for my child

By signing below, I request that payment of Medicaid benefits be made on my behalf to \_\_\_\_\_ for any services provided to my child. I give \_\_\_\_\_ permission to exchange my child's medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to \_\_\_\_\_ for services rendered.

## ③ Authorization and Consent

**Consent for Use of Protected Health Information & Claims Assignment:** I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me by a VaxStation or VaxCare representative. I relieve VaxCare, the VaxCare partner, the administering Nurse and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association. Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities, or arbitrate any claims as a representative member of a class or in a private attorney general capacity. In the case of occupational exposure, VaxCare has patient's permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). I understand I will be responsible for payment for the below vaccine(s), these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. Additionally, I understand that if I am a self-pay or no-pay patient receiving services that all funds should be paid at the time of service and not remit to VaxCare. If consenting for another: I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration.

SIGNATURE of PARENT or LEGAL GUARDIAN  DATE

### FOR OFFICE USE ONLY - BLACK INK ONLY

#### Vaccination Details (Lot number must be recorded. Please adhere label or print clearly.)

VFC  VAXCARE  LOT#   
 Prefilled Syringe 0.5 mL (36 mths & older)  LD  RD  LL  RL Other \_\_\_\_\_  
 DELIVERY:  IM  ID Other \_\_\_\_\_

ADMINISTRATOR SIGNATURE  DATE (MM-DD-YYYY)  ADMINISTRATOR ID   
 Nurse/Administrator hereby attest by my signature that the patient (or guardian of patient) in question has been provided access to and explained the Vaccine Information Sheets and appropriate Immunization Schedules, and has given verbal and written consent for vaccination(s).

**For patients receiving a Fluzone Standard, Fluzone Pediatric, or Fluzone High Dose vaccination:** The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO
1. Is the person to be vaccinated sick today? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases?	<input type="checkbox"/>	<input type="checkbox"/>