



"Keeping Communities Safe and Healthy"

SOUTHEAST HEALTH DISTRICT

Serving: Appling, Atkinson, Bacon, Brantley, Bulloch, Candler, Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tattnall, Toombs, Ware & Wayne counties

School Flu Campaign Newsletter

Dear Parent/Guardian:

This influenza (flu) season the Pierce County Health Department would like to help protect students from the flu by providing flu vaccine during school hours.

The following vaccine will be available:

- ❖ **Inactivated Quadrivalent Influenza Vaccine (QIV)**: a flu vaccine that is **given as a shot**.

For more information on the vaccine type above, please see the attached Vaccine Information Statement (VIS).

If your child has health insurance that covers vaccines, we may bill your insurance provider. If your insurance does not agree to pay the fee or you don't have insurance you will not be billed by us or by your insurance.

Children up to age 9 who have not received flu vaccine in the past may need a second dose approximately one month after the first dose. *If your child needs a second dose, we will send home another consent form for you to complete and sign before the second dose is given.*

If you would like to have your child vaccinated during the school based flu clinic please:

- 1) Read the "Vaccine Information Statement" included with this letter.
- 2) Sign and date the consent form to accept vaccination for your child.
- 3) Return the consent form to the school by **Monday, October 2nd, 2017.**
- 4) If the consent form is not signed, dated, and returned, your child will not be vaccinated.
- 5) School staff will let you know when the vaccination clinic will take place.

We thank you in advance for helping to keep our students safe and healthy.

Please note that participation and receipt of influenza vaccine through this program is completely voluntary.

- ❖ **Note: The intranasal (FluMist) vaccine will not be available this year. We will only provide injectable vaccine (the flu shot).**

If you have any questions about the vaccine or the vaccination clinics, please call:

Pierce County Health Department at 855-473-4374.

Your child's health care provider can also answer your questions regarding the influenza virus and may be able to give your child the seasonal influenza vaccine. For additional information please visit the CDC's influenza web site at <http://www.cdc.gov/flu>.

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): What you need to know

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.

Many Vaccine Information Statements are available in Spanish. See www.hhs.gov/vaccines. Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.hhs.gov/vaccines.

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.

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

Office Use Only



08/07/2015

42 U.S.C. § 300aa-26

NOTICE OF PRIVACY PRACTICES FOR PIERCE COUNTY BOARD OF HEALTH

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Pierce County Board of Health to maintain the privacy of your health information inform you of its legal duties and privacy practices with respect to your health information through this Notice of Privacy Practices notify you if there is a breach involving your protected health information agree to restrict disclosure of your health information to your health plan if you pay out-of-pocket in full for health care services, and abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this Notice at any time. The Notice will be posted on the DPH website at www.dph.georgia.gov. Copies of the Notice are available upon request.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment: We may use or disclose your health information to provide you with treatment or services. We may disclose your health information to doctors, nurses or other healthcare personnel involved in your care. For example, we may share your information with programs involved in your follow-up care, such as the Babies Can't Wait program. Also, the DPH Public Health Laboratory will return lab test results to the person who ordered the tests, and those results may be used for your treatment or follow-up care.

Payment: We may use or disclose your health information to bill and collect payment for the services that you receive. For example, your health insurance company may need to provide your health plan with information about the treatment you received so that it can make payment or reimbursement for services provided to you.

Health Care Operations: We may use and disclose information about you for health care operations. For example, we may review treatment and services to evaluate the performance of our staff in caring for you, and to determine what additional services should be provided.

Appointment Reminders, Follow-Up calls: We may use or disclose medical information about you to remind you of an upcoming appointment or to check on you after you have received treatment.

Individuals Involved in Your Care: If you do not object, we may disclose your health information to a family member, relative, or close friend who is involved in your care or assists in taking care of you. We may also disclose information to someone who helps pay for your care. We may disclose your health information to an organization assisting with disaster relief to help notify your family member, relative, or close friend of your condition, status and location.

Business Associates: We may disclose your information to contractors (business associates) who provide certain services to us. We will require these business associates to appropriately safeguard your information.

Public Health Activities: We may disclose your health information for public health activities which include: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting reactions to medications or problems with products or notifying a person of product recalls; and notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your medical information to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only disclose this if you agree, or when required or authorized by law or regulation.

Health Oversight Activities: We may disclose your health information to a health oversight agency that is authorized to conduct audits, investigations, inspections, licensure and other activities necessary to monitor the health care system, government programs and compliance with civil rights laws.

Judicial and Administrative Proceedings: We may disclose your health information if ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process, but only if reasonable efforts have been made to notify you of the request or to protect the health information requested.

Law Enforcement: We may release health information to law enforcement to comply with a court order, warrant, subpoena or similar process to identify or locate a suspect, fugitive, material witness or missing person about the victim of a crime in certain circumstances if we believe a death resulted from criminal conduct to report a crime occurring on our premises in emergencies, to report a crime, the location or victims of the crime, or the identity, description and location of the person committing the crime.

Research: Under certain circumstances we may use or disclose your health information for research. In most cases, we will ask for your written authorization before doing so. Sometimes, we may use or disclose your health information for research without your written authorization. In those cases, the use or disclose of your health information without your consent will be approved by an Institutional Review Board or Privacy Board.

Coroners, Medical Examiner and Funeral Directors: We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

To Avert a Serious Threat to Health or Safety: We may use or disclose your health information if necessary to prevent or lessen a serious and imminent threat to your safety, another person, or the general public. We will only disclose your information to a person who can prevent or lessen that threat.

National Security and Intelligence Activities and Protective Services for the President: We may disclose your health information to authorized federal officials conducting intelligence and other national security activities. We may also disclose your health information to authorized federal officials for the provisions of protective services to the President, other authorized persons, foreign heads of state or to conduct special investigations.

Military and Veterans: We may disclose the health information of Armed Forces personnel to appropriate military command authorities for the execution of their military mission. We may also disclose health information about foreign military personnel to foreign military authorities.

Inmates: If you are an inmate, we may disclose your health information to the law enforcement official or correctional institution having custody to provide you with health care, and to protect your health or safety or that of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation: We may release your health information for workers' compensation or similar programs that provide benefits for work-related injuries.



**2017-18 School Based Influenza Vaccine Consent Form
PIERCE COUNTY HEALTH DEPARTMENT**

Section 1: Information About the Student Who Will Receive Influenza Vaccine (please print)

STUDENT'S FIRST NAME	MIDDLE INITIAL	(LAST NAME)	SCHOOL NAME:	
DATE OF BIRTH (mm/dd/yyyy)	AGE	GENDER (Please circle) Male Female	TEACHER	GRADE
ETHNICITY (Please Circle) Not Hispanic/Latino Hispanic Latino	RACE (Please Circle): African American, White, Hispanic or Latino, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific Islander, Other		PARENT/ LEGAL GUARDIAN'S NAME	
HOME ADDRESS			PARENT/ GUARDIAN PHONE NUMBER(S)	
CITY	STATE	ZIP CODE	PARENT/ GUARDIAN E-MAIL	
INSURANCE INFORMATION: Does your child have Insurance that covers vaccines? <input type="checkbox"/> Yes / <input type="checkbox"/> No Please check health insurance provider below*: <input type="checkbox"/> Aetna <input type="checkbox"/> Medicaid/Amerigroup/Peachstate/Wellcare/CareSource <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Peachcare for Kids <input type="checkbox"/> Cigna <input type="checkbox"/> United Healthcare <input type="checkbox"/> Coventry <input type="checkbox"/> Other _____ <input type="checkbox"/> No Insurance			*Provide insurance provider/plan information below: Name of Policy Holder _____ Group# or Policy Type _____ Member ID# _____ Please attach a copy of the insurance card to this form	

Section 2: Medical Information: The following questions will help us to determine if this student can receive the influenza vaccine.

**Please circle Yes or No for each question.*

1. When was the student last vaccinated for flu (if known)?	DATE:	
2. Has the student ever had a serious allergic reaction to eggs?	Yes	No
3. Has the student ever had a serious reaction to any influenza (flu) vaccine?	Yes	No
4. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No

Section 3: Consent to vaccinate:

If this consent form is not filled out completely, signed, dated, and returned, the student will not be vaccinated at school.

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE

By signing below, I acknowledge that the student and medical information provided above is correct. I have been given a copy of the VACCINE INFORMATION STATEMENT for INFLUENZA VACCINE and the NOTICE of PRIVACY POLICY FORM. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine that will be given to the student that I am authorized to represent. I understand that participation and receipt of the influenza vaccine through this program is completely voluntary.

By signing below, I give permission for the student listed above to receive injectable influenza vaccine ("flu shot").

Signature of Parent/Legal Guardian: _____ **Date:** _____

FOR CLINIC USE ONLY

Inactivated Influenza Vaccine VIS 08-07-2015 Administration Route/Site: <input type="checkbox"/> IM / LD <input type="checkbox"/> IM / RD Mfg: _____ Lot # _____ Exp Date _____ PUBLIC/VFC \$PRIVATE/CP\$	_____ <p align="center">ENTRY CLERK DATE</p> <small>(Demographic info entered, MDCD/Insurance verified)</small> _____ <p align="center">NURSE SIGNATURE DATE</p>
---	---

PIN#: _____