Tennessee Department of Health School Located Influenza Vaccination Project
Student Consent Form and Influenza Immunization Documentation Form

If you want a Flu Vaccination given to your child, COMPLETE THE INFORMATION ON THE FRONT AND BACK OF THIS FORM AND SIGN.

PLEASE PRINT

School: _____ ***Home Room Teacher:*** _____ ***Grade :*** _____

Student: *Last Name* _____ *First Name:* _____ *MI :* _____

SEX: M F *DOB:* ____/____/____ *Current Age:* _____ *Child's SSN:* _____

RACE: ☐ *Asian* ☐ *Black* ☐ *Native American* ☐ *Pacific Islander* ☐ *White* ☐ *Other* ***ETHNICITY:*** *Hispanic* Y N

Address: _____ ***City:*** _____ ***State:*** _____ ***Zip:*** _____

Parent/Guardian: Last Name: _____ ***First Name:*** _____ ***MI:*** _____

Parent/Guardian Home Phone: (____) _____ ***Cell Phone:*** (____) _____

ALL QUESTIONS MUST BE COMPLETED BY CHECKING YES OR NO IN ORDER FOR THE STUDENT TO RECEIVE A FLU VACCINE The Nurse giving the vaccination will review the information on vaccination day.	**YES**	**NO**
1. Has your child ever received a flu vaccine?		
2. Has your child received at least 2 seasonal Influenza (flu) vaccine doses in their lifetime? If unsure, mark No.		
3. Has your child ever had a severe (life threatening) allergic reaction to the flu vaccine requiring urgent medical attention?		
4. Does your child have severe (life threatening) allergy to eggs (requiring urgent medical attention?) **If yes, describe:**		
5. Is your child allergic to vaccine components such as gentamicin, arginine, gelatin, MSG? **If yes, describe reaction:**		
6. Has your child ever had Guillain-Barre´ syndrome?		

Request for Administration of Influenza Vaccine for the above named recipient: I will receive information about the vaccine and special precautions on the Vaccine Information Sheet prior to my child receiving the vaccine and on the day of vaccination. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Tennessee Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

I understand that this document will be given to and retained by the public health department. I give permission for my child's school to retain a copy if needed.
I acknowledge that I have been given the Department of Health's Notice of Privacy Practices.
I give consent to bill TennCare and/or private insurance for the service provided.

This Consent Form is valid for administration of influenza vaccinations for six (6) months. It may be used to administer a second dose of influenza vaccine, if needed. I understand that I should report any changes of the above information to the health department prior to vaccination.

_____ _____
Parent/Guardian Signature **Date**

PLEASE COMPLETE THE INFORMATION ON THE BACK OF THIS FORM

PARENTS: Please answer all questions below to provide necessary billing information and to determine if your child

might be eligible for the Vaccine for Children (VFC) program.

Does your child have CoverKids or any type of private medical insurance? If yes, please complete the insurance information below :

Name of Insurance Plan_____ Does insurance cover vaccines? YES NO

Policy Number:_____ Group Number:_____

Name of policyholder _____ Member ID:_____

Address To File Claims:_____ Birth Date of policy holder: _____
(from back of card)

Does your child have TennCare? If yes, circle the health plan and provide ID number:

BlueCare/TennCare Select United Health Care/Americhoice Amerigroup

TennCare ID#_____

Is your child uninsured? YES NO

Is your child an American Indian or Alaska Native? YES NO

Nursing Immunization Documentation

AREA FOR OFFICIAL USE ONLY

VFC Eligible: YES NO

AREA FOR OFFICIAL USE ONLY

#1 Manufacturer: □ **Sanofi** □ **Seqirus** □ **GSK** □ **Other** _____

VIS Date: _____/_____/_____ **Site administered:** □ **Right Deltoid** □ **Left Deltoid**

Lot number: _____ **Signature**_____
Signature above indicates immunization given according to PHN Protocol

Date Given: _____ **Provider Number:** _____

#2 Manufacturer: □ **Sanofi** □ **Seqirus** □ **GSK** □ **Other**

VIS Date_____/_____/_____ **Site administered:** □**Right Deltoid** □ **Left Deltoid**

Lot number: _____ **Signature** _____
Signature above indicates immunization given according to PHN Protocol

Date Given: _____ **Provider Number:** _____

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

Department of Health. Authorization No. 343031. No. of copies, 450,000. This public document was promulgated at a cost of $0.03 per copy. August 2016.

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

Office Use Only

42 U.S.C. § 300aa-26

TN Department of Health

STATE OF TENNESSEE DEPARTMENT OF HEALTH

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

PLEASE REVIEW THIS CAREFULLY

OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

The Department of Health's workforce is required by the federal law entitled Health Insurance Portability and Accountability Act (HIPAA) to safeguard your Protected Health Information (PHI). PHI is individually identifiable information about your past, present or future health or condition; the provision of health care to you; and payment for health care. We are required to give you a notice of our privacy practices for the information we collect and keep about you.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand health information about you is personal and we are committed to protecting this information. This Privacy Notice applies to all of your health information, including (1) records relating to your care at a health department clinic (2) health care records received by the Department of Health from another source and (3) genetic information.

We are required by law to: (1) keep your PHI confidential; (2) give you this Privacy Notice; and (3) follow the terms of the current Privacy Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND OPERATIONS

The following categories describe different ways we may use and disclose your PHI.

- **For Treatment.** We may use or disclose your PHI to doctors, nurses, nutritionists, technicians or other health department personnel who are involved in taking care of you. We may disclose your PHI to people outside the health department who may be involved in your medical care such as prescriptions, lab work and x-rays.
- **For Payment.** We may use or disclose your PHI to get payment or to pay for health services you receive. For example, we may need to tell your health insurance about a treatment you need to obtain prior approval or to determine whether your insurance will pay for the treatment.
- **For Health Care Operations**. We may use or disclose your PHI for Department of Health's operations. This is necessary to manage the Department's programs and activities. For example, we may use PHI to review our services, programs and/or the quality of care we provide you.
- **Appointment Reminders**. We may use your PHI to contact you as a reminder that you have an appointment for treatment or services.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR PERMISSION

The law provides that we may use or disclose your PHI from our records (even after your death) without your permission in the following circumstances:

- **As Required By Law**. We will disclose medical information about you when required to do so by law, to investigate reports of abuse or neglect, and to report the incident to the appropriate enforcement agency.
- **Health Oversight Activities**. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections and licensure. These activities are necessary for the state and federal government to monitor the health care delivery system in Tennessee.
- **As Public Health Risks**. We may disclose PHI about you for public health activities. These activities may include the reporting of births and deaths and the tracking, prevention, or control of certain diseases, injuries and disabilities.

- **Research**. In certain circumstances, and under supervision of an institutional review board, we may disclose PHI to assist medical research.
- **To Avert a Serious Threat to Health or Safety**. We may use or disclose your PHI if necessary to prevent a serious threat to you or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **For Specific Government Functions**. We may disclose PHI to law enforcement, to government benefit programs relating to eligibility and enrollment, and for the interest of national security.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. In most cases, you have the right to look at or get copies of your paper records and your electronic records. You must make the request in writing. You may be charged a fee for the cost of copying your records.
- **Right to Amend.** If you believe there is a mistake or missing information in our record of your PHI, you may ask us to correct or add to your record. Your request must be made in writing and you must provide a reason that supports your request. We may deny your request under certain circumstances. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response you provide, appended to your PHI.
- **Right to Know What Health Information We Have Released**. You have the right to ask for a list of disclosures made of your PHI made on or after April 14, 2003 for purposes other than those listed in the Privacy Notice. You must request this list in writing and state the period of time the list should cover for a period of no longer than six (6) years. The first list you request within a twelve (12) month period will be free.
- **Right to Request Restrictions.** You have the right to ask us to limit how your PHI is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom the limits apply. You have the right to restrict disclosure to a health plan for services which you fully paid for out of pocket.
- **Right to Confidential Communications.** You have the right to ask that we communicate with you in a certain way or at a certain place. For example, you may ask us to send information to your work address instead of your home address. You must make your request in writing. You will not have to explain the reason for your request. We will honor all reasonable requests.
- **Right to Authorize Release of Information**. Other releases of your PHI can be made only if you request it and you can change your authorization at any time.
- **Right to Be Notified of Information**. You have a right to be notified in the event of a breach of unsecured PHI.
- **Right to a Paper Copy of This Notice**. You have a right to a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. You may obtain a copy of this notice at our website listed below. To obtain a paper copy of this notice, contact TDH Privacy Officer listed below. We reserve the right to change our privacy practices and this notice at any time. We will post a copy of the current notice in all our offices and at the department's website.

HOW TO GET MORE INFORMATION OR FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice, please contact the HIPAA PRIVACY OFFICER listed below. If you believe we have violated you privacy rights, you may file a written complaint with either of the agencies listed below. You will not be affected by filing a complaint.

HIPAA Privacy Officer
TN Department of Health
Compliance Office
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243
(615) 253-5637
877-280-0054 Fax: (615) 253-3926
email: privacy.health@tn.gov

Secretary
U.S. Department of Health & Human Services
200 Independence Ave. SW
HHH Building, Room 509H
Washington, DC 20201
TTY 886-788-4989
877-696-6775

Department of Health. Authorization No. 343513, 300,000 copies. This public document was promulgated at a cost of $0.01 per copy. November 2016 DH-0113

ED #1000080566