Fight the Flu in Arkansas

Dear Parent,

It is very important that you read this letter and follow through with the steps required so that your child can be protected from the flu.

This year, in partnership with the Arkansas Department of Health (ADH), school districts are holding Flu Immunization clinics in schools to provide flu vaccine for students.

For your child to receive the flu vaccine, you must:

1. Read the Vaccine Information Statement for the vaccine.
2. Read and complete the front and back of the Arkansas Department of Health (ADH) consent form.
3. PRINT clearly all information required on the ADH consent form.
4. Make sure you have signed the ADH consent form for the flu vaccine.
5. Sign the school district (FERPA) consent form (you may have signed this form at the beginning of the school year when your child was registered for school).
6. Return both consent forms to your child's school as quickly as possible.

This is a great opportunity for children to receive this vaccine with no charge to you. If you have insurance, ADH will ask your insurance company to pay for the cost of giving the vaccine. If you do not have insurance or your insurance does not pay for vaccines, there will still be no charge to you.

REMEMBER, only those students with the required completed paperwork (the signed ADH consent AND the school district FERPA consent) will be allowed to receive the flu vaccine.

If you should have any questions or concerns about the vaccines or the ADH consent form, please contact your local health unit.

Thank you.

ARKANSAS DEPARTMENT F JIEALTH PRIVACY NOTICE-Abbreviated Version

TIDS NOTICE DESCRIBES. HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO TIDS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Arkansas Department of Health (ADH) is committed to protecting your health information. ADH is required by law to protect the privacy of health information about you and that can be identified with you, which we call "protected health information," or "PHI" for short. We must give you notice of our legal duties and privacy practices concerning PHI, and we are required to abide by the terms of the notice currently in effect. This notice is to inform you about our privacy practices and legal duties related to the protection oftl1e privacy of your medical/health records that we create or receive.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

ADH staff will only use your PHI when doing their jobs. The purposes of the use and sharing of PHI are for treatment, payment for services and for Agency operations.

Treatment: Caregivers, such as nurses, doctors, therapists, nutritionists and social workers, may use your PHI to determine your plan of care. Individuals and programs within the ADH may share PHI about you in order to coordinate the services you may need, such as clinical examinations, therapy, nutritional services, medications, hospitalization, or follow-up care.

For Payment: The ADH may release PHI about you to Medicaid, Medicare, and/or your health plan/insurance carrier to obtain payment for our services. For example, we may need to give your health plan PHI about a clinical exam or vaccinations that you or your child received, so your health plan or Medicaid or Medicare will pay us for treatment or services.

For Operations: The ADH may use and release PHI about you to ensure that the services and benefits provided to you are appropriate. For example, we may use your PHI to evaluate our treatment and service programs (quality assurance). We may combine PHI about many individuals to research health trends, to determine what services and programs should be offered, or whether new treatments or services are useful. We may share your PHI with business partners who perform functions on behalf of the ADH. For example, our business partners may use your PHI to perform case management, coordination of care, or other activities, and they must abide by the same level of confidentiality and security as ADH when handling your PHI.

YOUR HEALTH INFORMATION RIGHTS

Release of your PHI outside of the boundaries of ADH-related treatment, payment, or operations, or as otherwise permitted by state or federal law, will be made *only* with your specific written authorization. This authorization is required to release the following types of information: Drug and Alcohol Abuse, Family Planning, HIV/AIDS, Mental Illness, Sexually Transmitted Diseases, and Women, Infants and Children (WIC) Program. You may revoke specific authorizations to release your PHI, in writing, at any time. If you revoke an authorization, we will no longer release your PHI to the authorized recipient(s), except to the extent that the ADH has already used or released that information in reliance of the original authorization. In addition, you have the following rights:

Right to Inspect and Copy: You may request to inspect or have a copy of any part of your health record. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

Right to Request Amendment: If you feel that the PHI the ADH has created about you is incorrect or incomplete, you may ask us to amend that information. The ADH may deny your request if you ask to amend information that: I) was not created by the ADH; 2) is not part of the PHI kept by the ADH; 3) is not part of the information which you would be permitted to inspect or copy; or 4) the infom1ation is determined to be accurate and complete.

Right to Request an Accounting of Health Information Releases: You may request an accounting of disclosures of your health information. The accounting does not include disclosures for purposes of treatment, payment, health care operations; disclosures required by law for purposes of national security; disclosures to jails or correctional facilities, authorized disclosures, and any disclosures made prior to April 14, 2003.

Right to Request Restrictions: You may request ADH to limit the use or disclosure of your PHI except for treatment, payment, and health care operations. ADH is not required by law to agree to your request.

Right to Request Confidential Communication: You may request, in writing, that ADH communicate with you in a different way or to a different location, for example, using a different mailing address or calling you at a different phone number.

Right to a Paper Copy of this Privacy Notice: You may request a paper copy of this Privacy Notice from ADH at any time.

All requests for inspecting, copying, amending, making restrictions, or obtaining an accounting of your PHI and any questions regarding this Privacy Notice must be directed to the Local Health Unit Administrator.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the ADH by contacting the ADH HIPAA Progran1 Consultant at (501) 661-2000 or by mail by writing to 4815 West Markham, Slot 31, Little Rock, AR 72205. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. If you request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. No action will be taken against you for exercising your rights or for filing a complaint.

ARKANSAS DEPARTMENT OF HEALTH

VACCINE INFORMATION STATEMENT

A Vaccine Information Statement (VIS) is a document, produced by the Centers for Disease Control and Prevention (CDC), that informs vaccine recipients – or their parents or legal representatives – about the benefits and risks of a vaccine they are receiving.

- To view the VIS for the Inactivated Influenza Vaccine (shot), go to

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html. This link can be viewed and downloaded from your desktop, laptop, tablet, smartphone or other web-based electronic device.

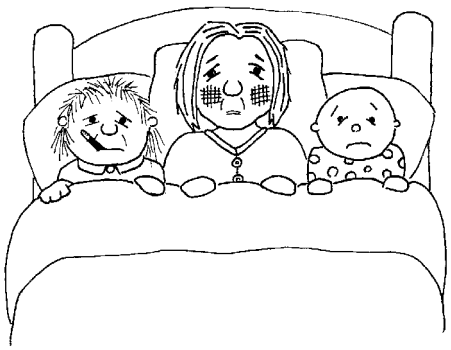
- For a paper copy of the shot VIS, you can go to your nearest Arkansas Department of Health Local Health Unit and receive a copy. Please call 1-800-462-0599 to find out the closest health unit to you.

- Copies of the flu VIS will also be available at the school the day of the flu clinic.

For more information, contact the Arkansas Department of Health's Immunization Section at 1-800-574-4040. Thank you.

ADH, 2022

Don't take chances with your family's health – make sure you all get vaccinated against influenza every year!



Here's how influenza can hurt your family . . .

Influenza can make you, your children, and your parents really sick.

Influenza usually comes on suddenly. Symptoms can include high fever, chills, headaches, exhaustion, sore throat, cough, and all-over body aches. Some people say, "It felt like a truck hit me!" Symptoms can range from mild to severe. When influenza strikes your family, the result is lost time from work and school and, possibly, doctor visits and trips to the hospital.

Influenza spreads easily from person to person.

An infected person can spread influenza when they cough, sneeze, or just talk near others. Some people might get flu by touching a surface contaminated with the flu virus and then touching their own mouth, nose, or eyes. People infected with flu don't have to feel sick to be contagious — they may even spread the flu virus to others the day before they have symptoms.

Influenza and its complications can be so serious that they can put you, your children, or your parents in the hospital – or lead to death.

Each year in the U.S., from 140,000 – 810,000 people are hospitalized and from 12,000 – 61,000 people die from influenza and its complications. The people most likely to be hospitalized and die are infants, young children, older adults, and people of all ages who have conditions such as heart or lung disease. But it's not only the youngest, oldest, or sickest who die: every year influenza kills people who were otherwise healthy.

Influenza can be a very serious disease for you, your family, and friends – but you can all be protected by getting vaccinated.

There's no substitute for yearly vaccination in protecting the people you love from influenza. Vaccination will help keep you and your loved ones safe from a potentially deadly disease. Get vaccinated every year, and make sure your children and your parents are vaccinated, too.

Get vaccinated every year! Get your children vaccinated! Be sure your parents get vaccinated, too!

immunization action coalition
IAC
immunize.org
Saint Paul, Minnesota · 651-647-9009 · www.immunize.org · www.vaccineinformation.org

www.immunize.org/catg.d/p4069.pdf • Item #P4069 (10/21)

ARKANSAS DEPARTMENT OF HEALTH
INFLUENZA SEASON -- IMMUNIZATION CONSENT FORM

For ADH use only ADH Clinic Code: _____ School LEA #: _____ Date of Service: _____
School Name: _____ School Grade: _____

Person Receiving Vaccine:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Age:** _____

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

If YES and further guidance is needed, notify the Regional CDNS	***YES**	**NO**	
Do you have a fever today? (If you have a fever on the day of the clinic it may prevent you from receiving the influenza vaccine.)			If any answer is YES, you may not be able to receive the flu vaccine.
Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
Have you ever had a serious reaction to a previous dose of flu vaccine, such as difficulty breathing, swelling of eyes or lips, wheezing, or immediate nausea or vomiting? Do you have a severe allergy to any flu vaccine component, or to any food, or medication? (i.e., gelatin, gentamicin, or neomycin)			
NOTE: Children aged 6 months through 8 years may require a second dose. Contact your health care provider or your ADH Local Health Unit in four weeks for more information.			
For school clinic use: Child's Homeroom Teacher: _____			

2. RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine and I understand the risks and benefits. To read the Vaccine Information Statement (VIS) for each vaccine visit the website to view current VIS: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html**
- **I give consent to the State/Local Health Department and its staff for the individual named below to be vaccinated with the flu vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Arkansas Department of Health's Privacy Notice.**
- **I understand that information about this flu vaccination will be included in the Arkansas Department of Health's Immunization Registry.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to the Arkansas Department of Health.**
- **I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.**
- **I agree that the photocopy of this form may be used instead of the original.**

The Arkansas Department of Health's Privacy Notice is on the website www.healthy.arkansas.gov, posted and available at the clinic site or accompanies this form.
Then sign in the box at right.

Please sign here

My signature below indicates I have read, understand, and agree to section **2. Release and Assignment** of the Influenza Season -- Immunization Consent Form and **Vaccine Information Statement (VIS).**

Signature of Patient/Parent/Guardian:

_____date_____

3. PATIENT INFORMATION:

(Legal) First Name: _____ MI: ____ Last Name: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Gender:** ☐ Male ☐ Female **Phone #: _____**

Street Address:_____ P.O. Box: _____ Apt. No. _____

City: _____ State: _____ Zip Code: ☐☐☐☐☐

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

4. INSURANCE STATUS (Check appropriate box**):**

Patient's Relationship to Insurance Policy Holder: ☐**Self** ☐**Spouse** ☐**Child** ☐**Other**

☐ **Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Insurance Company Name**: _____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER Information:

(Legal) First Name: _____ MI: ____ Last Name: _____

Policy Holder Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Email Address: _____**

Policy Holder's Employer Name: _____

Flu Vaccine Administration (Completed by ADH staff only)

SHOT CODE:

☐ 70: Quadrivalent (P-F) ≥ 6 months ☐ 72:Quadrivalent (P-F) ≥ 65 years

	Route	Site Code	Dosage mL	MFG Code	Lot Number
Flu Vaccine	☐ IM				

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

MFG Codes: SKB = GlaxoSmithKline, PMC = Sanofi, MED = MedImmune, SEQ = Seqirus

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____/_____/_____

FORM 4056 Revised 08/2022