# 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.

*2016-2017*

## ARKANSAS DEPARTMENT OF HEALTH PRIVACY NOTICE—Abbreviated Version

**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 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 of the 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: 1) 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 information 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 Program 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.

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**

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Vaccine Information Statement

Inactivated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26

Office Use Only

# 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: _____ ☐State ☐VFC ☐SCHIP

**Person Receiving Vaccine:**

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

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

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

| | YES | NO | |
|---|---|---|---|
| Have you ever had a serious allergic reaction to eggs? If yes, as a precaution, it is recommended you do not receive the flu vaccine until you have consulted your private health care provider. | | | If any answer is YES, you may not be able to receive the flu vaccine. |
| Have you ever had a serious reaction to a previous dose of flu vaccine? | | | |
| Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? | | | |
| **Child's Homeroom Teacher:** _____ **(For school clinic use)** | | | |

## 2. RELEASE AND ASSIGNMENT:

**I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine dated 08/07/2015 and understand the risks and benefits.**

**I give consent to the State/Local Health Department and its staff for the individual named 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.
Please sign on the first line 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.

**Signature of Patient/Parent/Guardian**:

_____ date _____

Signature and Title of Vaccine Administrator:

_____ 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:** ☐ White ☐ Hispanic/Latino ☐ Black/African-American ☐ American Indian/Alaska Native
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

## 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:** ☐☐ / ☐☐ / ☐☐☐☐

**Policy Holder's Employer Name:** _____

**Flu Vaccine Administration (Completed by ADH staff only)**

**SHOT CODE:**

☐ 48: Quadrivalent (P-F) 6- 35 months
☐ 44: Quadrivalent (P-F) ≥ 3 years

**Site Codes:** Right Arm = RA, Right Leg = RL, Left Arm = LA, Left Leg = LL

| Flu Vaccine | Route | Site Code | Dosage mL. | Dose Number (1st or 2nd) | MFG Code | Lot Number | Is a 2nd dose needed? | |
|---|---|---|---|---|---|---|---|---|
| | ☐ IM | | | | | | **YES** | **NO** |

Date Vaccine Administered: _____/_____/_____

FORM 4056 Revised 07/16

**CABOT PUBLIC SCHOOL DISTRICT**
602 North Lincoln, Cabot, Arkansas, 72023 (501) 843-3363

# FERPA Consent Form

## Influenza Vaccine (Seasonal Flu)

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99)

I, _____, give permission for my child, _____,
Parent/Guardian Name First and Last Name

_____, to participate in the Seasonal Flu School Immunization Clinic.
School

Parent/Guardian Signature_____Date Signed _____