



Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

2 Peachtree Street NW, 15th Floor
Atlanta, Georgia 30303-3142
dph.ga.gov

South Central Health District 5-1 • 2121-B Bellevue Road • Dublin, Georgia 31021

Phone: 478-275-6545 • FAX: 478-275-6575

Lawton C. Davis, M.D., District Health Director

Serving: Bleckley, Dodge, Johnson, Laurens, Montgomery, Pulaski, Telfair, Treutlen, Wheeler, & Wilcox counties

2017-18 School Flu Campaign

Dear Parents/Guardians:

This influenza (flu) season we would like to help protect our student body by providing flu vaccines during school hours. Again, the Health Department will be offering the flu shot (Inactivated Influenza Vaccine).

For more information about the flu vaccine, please see the Vaccine Information Statement attached.

If you have a billable insurance, your insurance provider will be charged.

If you would like your child to get vaccinated at our school clinic, please:

- Review the enclosed informational materials including the Vaccine Information Statement.
- Sign and return the enclosed Parental Consent Form to the school by the deadline.
- **If the consent form is not signed, dated, and returned, your child will not be vaccinated.**

Children through age 8 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.

Please understand that participation and receipt of the influenza vaccine through this program is completely voluntary. For additional information please visit the CDC's influenza web site at <http://www.cdc.gov/flu/> and <http://www.cdc.gov/flu/parents>.

If you have any questions, please call your local county health department.



We Protect Lives.



SOUTH CENTRAL HEALTH DISTRICT

Public Health Use Only

Aegis # _____

Clerk Initials: _____

****IMPORTANT: If your child receives the flu vaccine prior to the Health Department coming to the school, it is YOUR responsibility to contact your local Health Department and inform them.****

Section 1: Information about Student to Receive Influenza Vaccine (Please Print)

Students Legal Name (Last)	(First)	(MI)	Nickname	
Student's Date of Birth (mm/dd/yyyy)	Student's Age	Gender (Please circle) Male Female		Ethnicity: (Please circle one) Hispanic Not Hispanic/Latino
Parent/Legal Guardian's Name (PLEASE PRINT)	Parent/Legal Guardian's Phone Number(s)	Parent/Legal Guardian's Email		
Home Physical Address	Home Mailing Address (If different than physical)		City/State/Zip	
Race: (Please circle all that apply) :		African American	White	School Name
Hispanic/Latino		American Indian	Asian	Teacher
Alaska Native		Native Hawaiian	Other Pacific Islander	
Other: _____		Grade		
Insurance Information: Please check health insurance provider below.				Provide the insurance information for the provider you selected & attach a COPY of the insurance card. Medicaid # (if applicable): _____ Member ID (not group #): _____ Insurance Holder Name: _____
<input type="checkbox"/> No Insurance <input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Coventry				
<input type="checkbox"/> United Healthcare <input type="checkbox"/> Exchange Plan (MarketPlace) <input type="checkbox"/> Other _____				
<input type="checkbox"/> Peachcare or Medicaid: ___ Amerigroup ___ CareSource ___ Peachstate ___ Wellcare				

Section 2: Medical Information: Please answer all 3 questions.

1. Does the student use aspirin daily or regularly, has any significant chronic health conditions (diabetes, sickle cell disease, heart conditions, lung conditions, seizure disorders, cerebral palsy, muscle or nerve disorders, etc) or ever had Guillain-Barre Syndrome?	Yes	No
2. Has the student ever had a serious reaction to eggs or serious reaction to ANY flu vaccine? If yes, describe.	Yes	No
3. Has the student ever been vaccinated for the flu? If yes, when? _____	Yes	No

Section 3: Consent: *By signing below, I give permission for the student named above to receive the influenza vaccine.* I acknowledge that the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statement for the 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 the injectable (shot) influenza vaccine.

Signature of Parent/Legal Guardian: _____ Date: _____

****PLEASE BE SURE YOU COMPLETE THIS FORM COMPLETELY. FAILURE TO DO SO MAY KEEP YOUR CHILD FROM BEING VACCINATED. FORMS THAT CANNOT BE READ WILL ALSO BE DISCARDED.****

FOR CLINIC USE ONLY

Inactivated Influenza Vaccine: Admin Route: <input type="checkbox"/> IM/LA <input type="checkbox"/> IM/RA	MFG _____
Signature of Nurse _____	Lot#/NDC# _____
Date _____	Exp Date _____

FOR CLINIC USE ONLY:

Source: _____ Public _____ County Purchased

2nd Dose Needed? _____ Yes _____ No

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.



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

42 U.S.C. § 300aa-26

Office Use Only



NOTICE OF PRIVACY POLICIES FOR SOUTH CENTRAL HEALTH DISTRICT

SOUTH CENTRAL HEALTH DISTRICT
2121-B BELLEVUE ROAD, DUBLIN, GEORGIA 31021, PHONE: 478-272-2051
Serving Bleckley, Dodge, Johnson, Laurens, Montgomery, Pulaski, Telfair, Treutlen, Wheeler, and Wilcox Counties

Notice of Health Information Practices

THIS NOTICE OF HEALTH INFORMATION PRACTICES DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Introduction

It is important to us that you understand what information we collect about you and how it is used. We want you to know that we limit the collection and disclosure of information to only that which we believe is necessary to serve you and administer our business. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the health department a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

1. A basis for planning your care and treatment.
2. A means of communication among the many health professionals who contribute to your care.
3. A legal document describing the care you received.
4. A way that you or a third-party payer can verify that services billed were actually provided.
5. A tool in educating health professionals.
6. A source of data for medical research.
7. A source of information for public health officials charged with improving the health of this state and the nation.
8. A source of data for our planning and marketing.
9. A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.
10. A source of supporting data, which allows us to receive state and federal funding to provide public health services.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy. You can better understand who, what, when, where, and why others may access your health information. It allows you to make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the property of the health department, the information belongs to you. You have the following rights:

1. To receive a paper copy of this notice of information practices upon request.
2. To inspect and/or receive a copy of your health record.
3. To request an amendment to your health record.
4. To receive an accounting of disclosures of your health information.
5. To request communications of your health information by other means or at other locations.
6. To request a restriction on certain uses and disclosures of your information.
7. To revoke your authorization to use or disclose your health information except to the extent that action has already been taken.

Our Responsibilities

The health department is required to:

1. Maintain the privacy of your health information.
2. Provide you with this notice of our legal duties and privacy practices regarding information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you if we are not able to agree to a requested restriction.
5. Agree to reasonable requests from you to deliver health information in other ways or at other locations.

We reserve the right to change our practices and to make those changes effective for all protected health information we maintain. Should our information practices change, we will post the revised notice in our facility and provide you with a copy on request.

We will not use or disclose your health information without your permission except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you are comfortable with the content of this policy and will allow us to exchange information about you as outlined, then you need only to sign the acknowledgement attached. If you prefer to limit disclosure of information about you, please note that on the acknowledgement form and contact the Laurens County Board of Health Privacy Officer for further information.

If you believe your privacy rights have been violated, you can file a complaint with the health department's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. If you receive additional treatment from another physician, hospital, or laboratory we may share information with that provider about services you received in this facility .

We will use your health information for payment.

For example: A bill may be sent to you, a health insurance company, Medicaid or Medicare. The information on or with the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may contact or share information with other providers for payment services.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples are the providers of our computer software where electronic records are kept. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Planning/Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that that you may be eligible for.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. We may also disclose your health information to support funding from state and federal grants for the various public health services we provide and the administration of public health services.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.