

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 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

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 Live, Intranasal Influenza Vaccine (nasal spray), go to

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

- 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 either the nasal spray or 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.

Influenza is a serious disease...

Make sure your child is protected!

What is influenza?

Influenza (flu) is a serious disease caused by a virus.

Influenza can make your child feel miserable. Fever, cough, shaking chills, body aches, and extreme weakness are common symptoms.



How do you catch influenza?

Your child can catch influenza from people who cough, sneeze, or even just talk around him or her. It is very contagious.

Is influenza serious?

Yes. Tragically, every year infants, children, teens, and adults die from influenza.

Ask
your child's
healthcare provider
if your child is
up to date for all
vaccines!

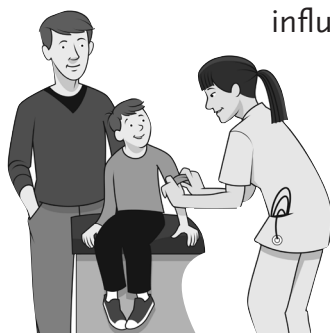
Influenza is dangerous for children as well as for people of all ages. Children younger than 2 years of age are at particularly high risk for hospitalization due to complications of influenza.

Influenza is not only serious for your child, but it can be serious for others, such as babies and grandparents, if your child passes the virus on to them.

Is my child at risk?

Yes. Anyone can become seriously sick from influenza – even healthy children.

How can I protect my child from influenza?



Vaccination is the best way to protect your child from getting influenza.

Everyone 6 months of age and older should get vaccinated against influenza every year.

Vaccination not only protects people who get immunized, it also protects others who are around them.

► For more information, visit www.vaccineinformation.org

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:

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

<i>*If YES and further guidance is needed, notify the Regional CDNS</i>	*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 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 foods or medications? (i.e., gelatin, gentamicin or neomycin)			
Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
Are you younger than 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No			If any answer is YES, you can receive only the <u>injectable</u> flu vaccine (shot), not the intranasal flu vaccine (flu mist).
Are you older than 49 years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you pregnant?			
Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? For a child 2 through 4 years: Have you been told by a health care provider that your child had wheezing or asthma in the past 12 months?			
Are you on long-term aspirin or aspirin-containing therapy? Do you take aspirin every day? Have you received influenza antiviral medications within the last 48 hours? (Tamiflu, Relenza, Rapivab, Xofluza)			
Have you received any of these vaccines in the last 28 days? Measles, mumps, rubella (MMR) <input type="checkbox"/> Yes <input type="checkbox"/> No Varicella (chickenpox) <input type="checkbox"/> Yes <input type="checkbox"/> No Intranasal influenza vaccine (Flu Mist) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have a severely weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer, rheumatoid arthritis, Crohn's disease, psoriasis, or radiation treatments)?			
Do you have close contact with a person who needs care in a protected hospital environment (for example, someone who has recently had a bone marrow transplant)?			
For parents NOT attending flu clinic with their child: If you answered No to all of the above questions, your child may receive either the flu shot (injectable) or flu mist (nasal spray). Please mark your preference of vaccine type below. If your preferred vaccine type is not available or marked, the nurse will give what is available unless you indicate otherwise. <input type="checkbox"/> Flu Shot <input type="checkbox"/> Flu Mist <input type="checkbox"/> No Preference <input type="checkbox"/> Do not give if my preference is not available			
Child's Homeroom Teacher: _____ (For school clinic use)			
• 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.			

2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. 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 _____

RELEASE AND ASSIGNMENT:

- I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine and the Live Attenuated Intranasal Vaccine (Flu Mist) and 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.

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:** / / **Email Address:** _____**Policy Holder's Employer Name:** _____**Flu Vaccine Administration (Completed by ADH staff only)****SHOT CODE:**☐ 70: Quadrivalent (P-F) ≥ 6 months ☐ 39: Quadrivalent Intranasal vaccine (P-F) 2 - 49 years

Flu Vaccine	Route	Site Code	Dosage mL.	MFG Code	Lot Number
	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal				

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:** _____/_____/_____

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