Fall 2021

Dear Parent/Guardian,

The S.C. Department of Health and Environmental Control (DHEC) is partnering with your school to provide flu vaccines to students. The flu vaccine will be available in 2 forms: flu shot and flu nasal spray. A flu vaccine is recommended by CDC and DHEC every year for everyone 6 months of age and older. It is the best way to protect your child against the flu.

I urge you to consider signing up your child to receive the flu shot or flu nasal spray in his/her school clinic. Here are a few things to keep in mind:

- Children in close settings like schools are at higher risk of getting sick with the flu and may spread it to other students and teachers as well as those in their household and community.
- If your child has asthma, diabetes or other chronic health conditions, they are more likely than other children to become very sick if they get the flu. It is especially important for children with any of these conditions to get the flu shot every year.
- Your child can get the flu shot or flu nasal spray at school from a DHEC nurse and you do not need to miss work to take them to the doctor's office.
- The flu is a primary reason that students (and parents) miss school days during influenza season.

Please look for information from your child's school about the online consent form. Information about the date and time of the flu clinic will also be provided by your child's school.

Don't forget to get yourself and your family vaccinated against the flu! Flu vaccine is available from your local DHEC health department and your health care provider. Those 12 years of age and older can receive the flu vaccine at a pharmacy which offers flu vaccine. I encourage you to find the facility that works best for you.

More information about the flu and flu vaccine clinics is available on our website at www.scdhec.gov/flu.

Sincerely,

Jonathan Knoche, MD, MPH, MSt
Medical Consultant, Immunization Division

S.C. Department of Health and Environmental Control
2600 Bull Street, Columbia, SC 29201 (803) 898-3432 www.scdhec.gov

Fall 2021

Dear Parent/Guardian:

The South Carolina Department of Health and Environmental Control (DHEC) is working with your school district to provide flu vaccines at your child's school this fall. This year DHEC is offering both the flu shot and the flu nasal spray. It is important that all children get vaccinated every year.

There will be no cost to you or your child for the flu vaccine/nasal spray at school. If applicable, payment from Medicaid will be made to DHEC on your behalf.

If you would like your child to get a flu vaccine or flu nasal spray at school:

1. Go to http://www.scdhec.gov/slvcconsent using your smartphone, computer or tablet and enter [11001001] as your validation code.
2. If you are not able to complete the online consent, complete the front of the attached form and return it to school within (5) days of receiving this letter.

If your child is under the age of 9, he or she may need to get a second flu vaccine or flu nasal spray for the best protection. You will be notified if your child will need a second flu vaccine or flu nasal spray.

If your child does not receive the flu vaccine or flu nasal spray at school, please contact your child's healthcare provider or health department to get the flu vaccine or nasal spray.

Sincerely,

Jonathan Knoche, MD, MPH, MSt
Medical Consultant, Immunization Division

CR-011087 (10/2021)

Once you have returned the Parent Consent Form, please contact the DHEC Regional Immunization Office for your county before the scheduled vaccination clinic, if any of the following events occur:

- There are any changes in your child's health.
- You decide you no longer want your child to receive the flu vaccine at school.

DHEC Regional Immunization Office Contact Information:

- Allendale, Bamberg, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, and Orangeburg counties: **(843) 953-0080**.
- Aiken, Barnwell, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, Newberry, Richland, Saluda, York counties: **(803) 602-2073**.
- Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Spartanburg, Union counties: **(864) 596-2227 Ext. 246**.
- Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg counties: **(843) 413-6404**.

S.C. Department of Health and Environmental Control
2600 Bull Street, Columbia, SC 29201 (803) 898-3432 www.scdhec.gov

PARENT CONSENT FOR SEASONAL INFLUENZA VACCINATION

FOR CLINIC USE ONLY	School District ID	School Name

STUDENT INFORMATION (use black ink only)

STUDENT FIRST NAME	MI	STUDENT LAST NAME	AGE	GRADE

DATE OF BIRTH(MM/DD/YYYY) / /	GENDER ☐ MALE ☐ FEMALE	SCHOOL	HOMEROOM TEACHER

RACE	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White	ETHNICITY	☐ Hispanic or Latino ☐ Not Hispanic or Latino

STREET ADDRESS	CITY	STATE	ZIP

PARENT/GUARDIAN FIRST NAME	PARENT/GUARDIAN LAST NAME	PARENT/GUARDIAN CELL TELEPHONE ( ) -

PARENT/GUARDIAN EMAIL ADDRESS	PARENT/GUARDIAN HOME TELEPHONE ( ) -

INSURANCE INFORMATION (fill out completely)

Does your child have SC Medicaid? ☐ NO ☐ YES	If yes, provide your child's SC Medicaid ID number:
Does your child have health insurance? ☐ NO ☐ YES	If yes, does your insurance cover flu vaccine? ☐ NO ☐ YES

INFLUENZA VACCINATION SCREENING QUESTIONS (answer all questions)

Question	NO	YES
1. Has your child ever had a <u>serious reaction</u> to eggs **OR** a serious reaction to a previous flu vaccine that caused any of the following: wheezing, trouble breathing, hives and itching all over the body, swelling in the mouth or throat, very low blood pressure or shock?	☐	☐
2. Has your child ever had Guillain-Barré Syndrome (a rare type of temporary severe muscle weakness and paralysis)?	☐	☐

If you answered YES to either question 1 or 2, your child cannot receive the 2021-2022 seasonal influenza vaccine at school. Please contact your child's primary healthcare provider.

Question	NO	YES
3. Has your child received any vaccine(s) within the past 30 days? If yes, list: Vaccine Name: ________ Date given: ________	☐	☐
4. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidney, liver, nerves, or blood (including anemia); or have a cochlear implant or spinal fluid leak, or no spleen?	☐	☐
5. Does your child take aspirin or a medication that contains aspirin every day?	☐	☐
6. Does your child have a weak immune system? (for example, treatment for cancer or HIV/AIDS, or taking medications such as steroids that may cause the immune system to be weak)	☐	☐
7. Is your child pregnant? (Please discuss this question with your child for verification)	☐	☐
8. Does your child have close contact with a person who needs care in a protected environment? (For example, someone who is in a bone marrow transplant unit.)	☐	☐
9. If your child is age 2-4 years of age, has your child had a wheezing episode in the past 12 months?	☐	☐
10. Did your child recently receive any of the following antivirals in the specified time frames below: • oseltamivir or zanamivir in the last 48 hours • peramivir in the last 5 days • baloxavir in the last 17 days	☐	☐

If you answered YES to *any* questions 3-10, your child cannot receive the nasal spray flu vaccine. He/she will receive the flu shot.	If you answered NO to questions 3-10, please select the preferred vaccine for your child: ☐ Flu Shot (Inactivated Influenza Vaccine quadrivalent {IIV4}) ☐ Nose/Nasal Spray (Live Attenuated Influenza Vaccine {LAIV})

Please answer if your child is under 9 years old:
Has your child received at least two doses of influenza vaccine prior to July 1, 2021?
If no or unsure, he/she may need 2 doses of flu vaccine this season.

NO ☐ YES ☐ UNSURE ☐

YOU MUST SIGN ON NEXT PAGE FOR CONSENT TO BE ACCEPTED

AUTHORIZATION AND CONSENT

By signing below, I consent to the use and disclosure of my child's personal health information for public health purposes and program evaluation. DHEC's Privacy Notice can be found at the following link: http://www.scdhec.gov/sites/default/files/Library/ML-025046.pdf or a copy of the notice will be provided upon request.

If applicable, by signing below, I request that payment of Medicaid benefits be made on my behalf to DHEC for any services provided to my child. I give DHEC permission to exchange my child's medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to DHEC for services rendered.

Vaccine Authorization: I voluntarily request DHEC to provide seasonal influenza vaccine for my child named above, and consent for my child to receive the seasonal influenza vaccine at school, to be administered by DHEC staff. I have read and answered the questions on the previous page carefully and accurately, and I understand that incorrect information could cause serious risks to my child. I understand that the vaccine will be given according to Advisory Committee on Immunization Practices (ACIP) recommendations and the answers I provided to the screening questions 1-9 on the previous page. I have read the Vaccine Information Statement for the flu vaccines: Flu Shot: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf or Nasal spray: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flulive.pdf. I have had an opportunity to ask questions about the vaccine. I understand the risks and benefits of the vaccine. In addition, I consent to my child receiving a second dose of the seasonal influenza vaccine, administered by DHEC, at a school clinic, if my child is less than 9 years old and a second dose is recommended by the U.S. Centers of Disease Control and Prevention (CDC). In case of occupational exposure and deemed necessary, I consent to my child's blood testing for child and employee safety. I understand that immunization information about my child will be reported to SC Immunization Registry for public health purposes. I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

SIGNATURE OF PARENT OR LEGAL GUARDIAN		DATE / /

VACCINATION DETAILS (Influenza V04.81) FOR CLINIC USE ONLY – BLACK INK ONLY

FIRST DOSE

VACCINE ☐ IIV4 ☐ LAIV	ELIGIBILITY ☐ VFC MEDICAID ☐ VFC AMERICAN INDIAN/ALASKA NATIVE ☐ VFC UNINSURED (NO INSURANCE) ☐ STATE UNDERINSURED ☐ STATE INSURED		
VIS DATE 08/06/2021	MANUFACTURER: ☐ GLAXOSMITHKLINE ☐ ASTRA ZENECA ☐ SANOFI PASTEUR LOT NUMBER	SITE OF ADMINISTRATION ☐ LD ☐ RD ☐ Nasal ☐ Other______	
NURSE SIGNATURE	Nurse: I hereby attest by signature below that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.	DATE / /	
		ECODE	COUNTY CODE
PATIENT'S/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE	Teacher: I hereby attest by signature below that the identity of the patient in question has been verified.	DATE / /	

☐ "What to Know After..." given to student ☐ Unable to vaccinate due to ____________ "Unable to Vaccinate" form given to student/school.

SECOND DOSE

VACCINE ☐ IIV4 ☐ LAIV	ELIGIBILITY ☐ VFC MEDICAID ☐ VFC AMERICAN INDIAN/ALASKA NATIVE ☐ VFC UNINSURED (NO INSURANCE) ☐ STATE UNDERINSURED ☐ STATE INSURED		
VIS DATE 08/06/2021	MANUFACTURER: ☐ GLAXOSMITHKLINE ☐ ASTRA ZENECA ☐ SANOFI PASTEUR LOT NUMBER	SITE OF ADMINISTRATION ☐ LD ☐ RD ☐ Nasal ☐ Other______	
NURSE SIGNATURE	Nurse: I hereby attest by signature below that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.	DATE / /	
		ECODE	COUNTY CODE
PATIENT'S/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE	Teacher: I hereby attest by signature below that the identity of the patient in question has been verified.	DATE / /	

☐ "What to Know After..." given to student ☐ Unable to vaccinate due to ____________ "Unable to Vaccinate" form given to student/school.

Notes:

PRE-CLINIC SCREENING- FOR CLINIC USE ONLY	STUDENT NAME
FIRST DOSE ELIGIBILITY: ☐ VFC MEDICAID ☐ VFC AMERICAN INDIAN/ALASKA NATIVE ☐ VFC UNINSURED (NO INSURANCE) ☐ STATE UNDERINSURED ☐ STATE INSURED	
SECOND DOSE NEEDED? ☐ NO ☐ YES	MCI Number
SECOND DOSE ELIGIBILITY: ☐ VFC – MEDICAID ☐ VFC AMERICAN INDIAN/ALASKA NATIVE ☐ VFC UNINSURED (NO INSURANCE) ☐ STATE UNDERINSURED ☐ STATE INSURED	Date of Birth / /