Washington County-Johnson City Health Department
Sydney Butterfield, Director
219 Princeton Road
Johnson City, Tennessee 37601
Phone: 423-975-2200

Dear Parent:

The Washington County Health Department and the Washington County/Johnson City School System have partnered to provide seasonal influenza (flu) vaccinations at your child's school. There is no charge for the vaccine this year.

Health Department nurses will vaccinate children and school staff using the injectable (shot) flu vaccine. Clinics will begin as soon as the vaccine arrives at the health department (usually middle to late fall).

If you would like for your child to receive flu vaccine, please fill out the front page of the attached consent form and return to the school **within two weeks**. Be sure to sign the form as this will be your permission for your student to receive the vaccine. You must fill out a separate consent form for each student you would like to receive the vaccine. If at a later date you change your mind and do not wish for your child to receive flu vaccine at the school, please notify the school prior to the clinic date. This service to the students and staff is being done to decrease the impact of seasonal flu in our communities and to decrease school absenteeism.

If you have any questions, please call the Washington County Health Department at 423-975-2200.

Sincerely,

Beth Denney, RN
Nursing Supervisor

Tennessee Department of Health School Located Influenza Vaccination Project
Student Influenza ("Flu") Consent & Documentation Form

If you want a Flu Vaccination given to your child, COMPLETE THE INFORMATION ON THE FRONT OF THIS FORM AND SIGN. If NO, stop here and discard the form.

School:					
Grade:	Home Room Teacher:				
Child Information					
Last Name:	First Name:			MI:	DOB: / /
Address:	City:		State:	Zip:	Current Age:
Sex: ❑M ❑F	SSN:	Phone: ( )		Cell Phone: ( )	
Race: ❑Asian ❑Black ❑Native American ❑Pacific Islander ❑White ❑Other: _____				Ethnicity: Hispanic ❑Yes ❑No	
Parent /Guardian Information					
Last Name:	First Name:		MI:	Daytime Phone: ( )	
Child's Physician/Health Care Provider Information					
Name:	Address:			Phone #:( )	

Do you have TennCare, Medicare, or any type of private medical insurance? ❑Yes ❑No

Please mark below what applies to your child.

18 years or younger:	❑TennCare ❑Uninsured ❑American Indian or Alaska Native ❑Underinsured (insurance does not cover vaccines) ❑Private Insurance
19 years or older:	❑Insured ❑Uninsured

ALL QUESTIONS MUST BE COMPLETED BY CHECKING YES OR NO IN ORDER FOR THE PATIENT TO RECEIVE VACCINES **The Nurse giving the vaccination will review the information.**	**YES**	**NO**
1. Does the child have allergies to medications, food, a vaccine component, or latex? If yes, please list.		
2. Is the child sick today?		
3. Has the child had a serious reaction to a vaccine in the past? If yes, please explain.		
4. Is the patient pregnant or is there a chance she could become pregnant during the next month?		
5. Has your child had a brain or other nervous system problem?		
6. Has your child ever felt dizzy or faint before, during, or after a shot?		
7. Is your child anxious about getting a shot?		
8. Have you received and reviewed the CDC VACCINE INFORMATION STATEMENT?		
9. Has your child ever received a flu vaccine?		
10. Has your child received at least 2 flu vaccine doses prior to July 1, 2024?		

Request for Administration of Vaccines for the above named recipient: I received information about the vaccine requested and special precautions on the Vaccine Information Sheets prior to my child receiving vaccine. I have had an opportunity to ask questions regarding the vaccines and understand the risks and benefits.

I request and voluntarily consent that the vaccines agreed to below be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Tennessee Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

Influenza Vaccine

I understand that this document will be given to and retained by the Tennessee Department of Health. I give permission for my child's school to retain a copy if needed. I acknowledge that I have been given the Department of Health's Notice of Privacy Practices. I understand that immunizations/vaccines my child receive will be sent to the State Immunization Registry and the Tennessee Immunization Program.
This Consent Form is valid for administration of vaccinations for twelve (12) months. I understand that I should report any changes of the above information to the health department prior to vaccination.

Parent/Guardian Signature: _____ **Date:** _____

AREA FOR OFFICIAL USE ONLY

Staff Only: Assess VFC eligibility ❑Yes ❑No

❑ The Child's identity has been confirmed by TDH staff (staff initials) with a minimum of two of the following:		
❑ Child states DOB	❑ Child states parent name on form	❑ Child states address on form
❑ Child unable to provide 2 identifiers to TDH Staff. The child's identity has been confirmed by responsible school personnel below:		
Name:	Signature:	
Title:		

VACCINE	Date	Dose Volume	Inject. Site & Route	Mftr.	Lot#	VIS/ISS Rev.Date
Influenza						

Provider's Signature: (signature indicates immunization given according to PHN protocol)

Signature	Date	Provider #

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 vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu.**

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

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. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do 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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- 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**.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS CAREFULLY

STATE OF TENNESSEE
DEPARTMENT OF HEALTH

Effective Date: March 2013
(Revised 06/13)

OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

The Department of Health's workforce is required by the federal law entitled Health Insurance Portability and Accountability Act (HIPAA) to safeguard your Protected Health Information (PHI). PHI is individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for health care. We are required to give you a notice of our privacy practices for the information that we collect and keep about you.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand that health information about you is personal, and we are committed to protecting this information. This Privacy Notice applies to all of your health information, including (1) records relating to your care at a health department clinic (2) health care records received by the Department of Health from another source and (3) genetic information.

We are required by law to: (1) keep your PHI confidential; (2) give you this Privacy Notice; and (3) follow the terms of the current Privacy Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND OPERATIONS

The following categories describe different ways we may use and disclose your PHI.

- **For Treatment.** We may use or disclose your PHI to doctors, nurses, nutritionists, technicians, or other health department personnel who are involved in taking care of you. We may disclose your PHI to people outside the health department who may be involved in your medical care such as prescriptions, lab work and x-rays.

- **For Payment.** We may use or disclose your PHI to get payment or to pay for health services that you receive. For example, we may need to tell your health insurance about a treatment you need in order to obtain prior approval or to determine whether your insurance will pay for the treatment.

- **For Health Care Operations.** We may use or disclose your PHI for Department of Health's operations. This is necessary to manage the Department's programs and activities. For example, we may use PHI to review our services, programs, and/or the quality of care that we provide you.

- **Appointment Reminders.** We may use your PHI to contact you as a reminder that you have an appointment for treatment or services.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR PERMISSION

The law provides that we may use or disclose your PHI from our records (even after your death) without your permission in the following circumstances:

- **As Required By Law.** We will disclose medical information about you when required to do so by law, to investigate reports of abuse or neglect, and to report the incident to the appropriate law enforcement agency.

- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections and licensure. These activities are necessary for the state and federal government to monitor the health care delivery system in Tennessee.

- **As Public Health Risks.** We may disclose PHI about you for public health activities. These activities may include the reporting of births and deaths and the tracking, prevention, or control of certain diseases, injuries and disabilities.

- **Research.** In certain circumstances, and under supervision of an institutional review board, we may disclose PHI in order to assist medical research.

- **To Avert a Serious Threat to Health or Safety.** We may use or disclose your PHI if necessary to prevent a serious threat to you or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **For Specific Government Functions.** We may disclose PHI to law enforcement, to government benefit programs relating to eligibility and enrollment, and for the interest of national security.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** In most cases, you have the right to look at or get copies of your paper records and your electronic records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

- **Right to Amend.** If you feel that there is a mistake or missing information in our record of your PHI, you may ask us to correct or add to your record. Your request must be made in writing, and you must provide a reason that supports your request. We may deny your request under certain circumstances. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response you provide, appended to your PHI.

- **Right to Know What Health Information We Have Released.** You have the right to ask for a list of disclosures made of your PHI made on or after April 14, 2003 for purposes other than those listed in the Privacy Notice. You must request this list in writing and state the period of time the list should cover for a period of no longer than six (6) years. The first list you request within a twelve (12) month period will be free.

- **Right to Request Restrictions.** You have the right to ask us to limit how your PHI is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom the limits apply. You have the right to restrict disclosure to a health plan for services which you fully paid for out of pocket.

- **Right to Confidential Communications.** You have the right to ask that we communicate with you in a certain way or at a certain place. For example, you may ask us to send information to your work address instead of your home address. You must make your request in writing. You will not have to explain the reason for your request. We will honor all reasonable requests.

- **Right to Authorize Release of Information.** Other releases of your PHI can be made only if you request it and you can change your authorization at any time.

- **Right to Be Notified of Information.** In the event of a breach of unsecured PHI.

- **Right to a Paper Copy of This Notice.** You have a right to a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. You may obtain a copy of this notice at our Website listed below. To obtain a paper copy of this notice, contact the State's Privacy Officer listed below. We reserve the right to change our privacy practices and this notice at any time. We will post a copy of the current notice in all our offices and at the Department's Website.

HOW TO GET MORE INFORMATION OR COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice, please contact the HIPAA PRIVACY OFFICER listed below. If you believe we have violated you privacy rights, you may file a written complaint with either of the agencies listed below. You will not be affected by filing a complaint.

HIPAA Privacy Officer
TN Department of Health
Compliance Office
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243
(615) 253-5637
877-280-0054 Fax: (615) 253-3926
email: privacy.health@tn.gov

Secretary
U.S. Department of Health & Human Services
200 Independence Ave. SW
HHH Building, Room 509H
Washington, DC 20201
TTY 886-788-4989
877-696-6775

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