CentraCare®

Dear Parents/Guardians:

CentraCare is working with your local school to administer the seasonal influenza vaccine to students in grades K-12.

We will be holding the Influenza vaccination clinic on WEDENSDAY ***October*** **11, 2024,** at MACCRAY Schools. Please complete and return the consent forms to your child's school by **October 4th,2024.**

If you would like your child to receive the influenza vaccine (flu shot or mist), please read, and **fill out** the enclosed form(s) and **sign** the **Admission Consent.** The Admission Consent is giving consent for your child to receive the vaccine and for us to bill your insurance. Completing these forms will allow us to give your child the vaccine. We will file charges for the vaccine with your insurance provider. Any unpaid balance will be your responsibility.

Please read the Vaccine Information Sheet included with this letter about the disease and the vaccine.

If at any time you change your mind about having your child vaccinated or have questions about the flu vaccine, please contact your child's clinic. You can also visit our website at www.centracare.com

Sincerely,

CentraCare

CentraCare®

Staff Vaccination Clinic Consent Form

MUST FILL OUT ALL AREAS OF THIS FORM IN ORDER TO RECEIVE VACCINE

Information to Receive Vaccine: *(Please print)*

Name – Last:	First:	MI:	DOB

Gender (circle): Male / Female	Address:	City:	State:

Screening for Vaccine Eligibility *Please mark YES or NO for each question.*

The answers to the following questions will help us to determine if you can be vaccinated:	YES	NO
Flu Vaccine Screening Questions:		
Have you had a serious reaction to any vaccine in the past?	☐	☐
Do you have currently have an active illness or fever?	☐	☐
**Please monitor for any illness and notify the school if you become ill. You will not be vaccinated if you have a fever or active illness.		
COVID-19 Booster Vaccine Screening Questions:		
Has it been at least 2 months since your last dose of COVID-19 vaccine?	☐	☐
Have you been treated for COVID in the past 90 days?	☐	☐
Are you immunocompromised?	☐	☐
Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-A) in the past 90 days?	☐	☐
Have you had a severe allergic reaction to any vaccine or injectable therapy?	☐	☐
Do you have an allergy to polyethylene glycol or polysorbate?	☐	☐

Insurance Information

Insurance Company Name:		Subscriber's/Policy Holder's Name:
Insurance Claims Address:		Subscriber's/Policy Holder's Date of Birth:
ID Number:	Policy or Group Number:	Subscriber's/Policy Holder's Phone Number:
Medical Assistance Number:		

Consent for Vaccination:

I have read or had explained to me the Vaccine Information Statement for the influenza vaccine and/or the Moderna COVID-19 Factsheet and understand the risks and benefits. I **give consent** to CentraCare and their staff to administer the (check one or both):

_____ Flu Vaccine _____ Moderna COVID-19 Booster Vaccine

Your signature on the Admission Consent is required to be vaccinated.

FOR STAFF USE ONLY

Vaccine	Route & Dose	Date Dose Administered	Injection Site	Vaccine Manufacturer	Lot Number
FluLaval	0.5 mL IM				
Moderna COVID-19 Vaccine	0.25 mL IM				
Name and Title of Vaccine Administrator:					

CentraCare

Influenza Vaccination Clinic Consent Form-Student

MUST FILL OUT ALL AREAS OF THIS FORM IN ORDER TO RECEIVE VACCINE

Information About Child to Receive Vaccine: *(Please print)*

Child's Name – Last:	First:	M.I.
Child's Date of Birth: Month _____ Day _____ Year _____	Child's Gender (circle) Male / Female	
Child's Doctor's Name/Clinic:		
Grade:	Teacher:	

Parent/Legal Guardian's Name – Last:	First:	M.I.
Address:		
City:	State:	Zip:

Screening for Vaccine Eligibility *Please mark YES or NO for each question.*

The answers to the following questions will help us to determine if your child can be vaccinated:	*YES*	*NO*
Does your child have an active illness or fever today? *Monitor for any illness and notify the school.*	☐	☐
Has your child had a serious reaction to an influenza vaccination?	☐	☐
Does your child have any of the following? Heart disease, lung disease, kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or have a cochlear implant or spinal fluid leak, or no spleen.	☐	☐
Does your child have a weakened immune system?	☐	☐
Is your child receiving or recently received influenza antiviral medications?		
Is your child on long-term aspirin treatment?	☐	☐
Is your child pregnant or could they become pregnant in the next month?	☐	☐
Has your child ever had Guillain-Barre syndrome?	☐	☐
Does your child live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?	☐	☐
Has your child received any live virus vaccinations, i.e. MMR, chicken pox, in the past 4 weeks?	☐	☐

Insurance Information

Insurance Company Name:		Subscriber's/Policy Holder's Name:
Insurance Claims Address:		Subscriber's/Policy Holder's Date of Birth:
ID Number:	Policy or Group Number:	Subscriber's/Policy Holder's Phone Number:
Medical Assistance Number:		

Minnesota Vaccines for Children Program MnVFC Screening: MnVFC Eligibility Criteria. Please √ only one box.	
☐	Uninsured
☐	Enrolled in MN Healthcare Program (MA, PMAP, GAMC, MnCare)[1]
☐	American Indian or Alaskan Native
☐	None of the above

***I prefer for my child to receive the (must select one): _____Injection (Shot) OR _____ Nasal Spray**

Consent for Child's Vaccination:

I have read or had explained to me the **Influenza** Vaccine Information Statement for the influenza vaccine and understand the risks and benefits. I **give consent** to CentraCare for my child named at the top of this form to be vaccinated with this vaccine.

***Your signature on the Admission Consent is required to vaccinate your child.**

*****STAFF USE ONLY								
Vaccine	Date Dose Administered	Injection Site	Lot Number		Vaccine	Date Dose Administered	Injection Site	Lot Number
FluLaval					Flumist			

CentraCare Clinic

Admission Consent

I request that services and care be furnished to me by CentraCare Clinic:

1. **General Consent for Treatment**
   I hereby agree to the performance of such procedures and treatments that in the opinion of the attending/consulting physician/provider are deemed necessary.

2. **Release of Information**
   Health Information includes transfer records, medical records, photos, financial and other information. I authorize the CentraCare Clinic or CentraCare Health System to release information about me as follows:
   A. To all third party insurance carriers, health service plans or health maintenance organizations or third-party administrators (my insurance company). This release of information is necessary to determine payment of my clinic bill, payment of claims, and/or fraud investigation.
   B. For quality of care review studies.
   C. To health care providers for my continuing patient care and billing purposes.
   D. Most clinical research using data from your medical record will require CentraCare to obtain a separate consent. CentraCare will not obtain separate consent if (a) the researcher agrees to certify that he/she will only use the health information to prepare for a research project and that he/she will maintain the confidentiality of the information and will not remove any of the health information from CentraCare Health or (b) an Institutional Review Board (IRB), determines in advance that use or disclosure of your health information meets specific criteria required by law. If you do not wish to have your data shared for research in these two instances, you may opt out by initialing the below.

      _____

   E. Incidental and limited release of information to independent contractors and technicians in order to repair information systems. Such independent contractors sign a confidentiality agreement prior to access.
   F. I understand that CentraCare Clinic is a part of the CentraCare Health System and I recognize that my information will be shared with other CentraCare Health System facilities for patient care and billing purposes.
   G. I understand certain circumstances require disclosure of information to organizations such as health departments or the Centers for Disease Control and Prevention. This may include cases of HIV, tuberculosis, viral meningitis, and other diseases.

3. **Assignment of insurance benefits and guarantee of account:**
   CentraCare may bill my insurance. I ask that my insurance payments be made to CentraCare and to those providing my care. CentraCare may share my health and account records with payers as needed for billing, payment and claims. I will pay for all services not covered by a third party, such as insurance, including emergency services. I understand and agree that my insurance company may share my past, current and future health and account records with CentraCare about services I've received from CentraCare and other care providers unrelated to CentraCare. These records may be used by CentraCare as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

   __ My insurance company may not release any identifiable health records from providers unrelated to CentraCare for the purposes described above.

4. **Cellular Phone Contact Policy**
   By providing us with a telephone number for a cellular phone or other wireless device, you are expressly consenting to receiving communications- including but not limited to prerecorded or artificial voice message calls, text messages, and calls made by an automatic telephone dialing system – from us and our affiliates and agents at that number. This express consent applies to each such telephone number that you provide to us now or in the future and permits such calls regardless of their purpose. Calls and messages may incur access fees from your cellular provider.

5. **Applicability to Other Providers**
   I hereby make the above consents/authorizations/assignments/guarantees applicable to other providers furnishing service to me while receiving care from CentraCare Clinic, and to providers for whom the clinic, by agreement, provides information and services for their billing and patient care purposes, whether by electronic database or otherwise.

6. This authorization will remain in effect for maximum of one year from the date of signature.

I understand that my medical record is part of the CentraCare Health (CCH) Electronic Medical Record. St Cloud Hospital and CentraCare Clinics share provide both CCH and non-CCH organizations access to this integrated Electronic Medical Record System. This access is secure and provides improved patient care, patient safety, and the coordination of care across the region. A list of these non-CCH organizations will be provided to the patient upon request.

Signature of patient/authorized representative/relationship		Date
Reason patient did not sign:		
Patient Name	MRN	Patient DOB

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Live, Intranasal): *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 of age 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. Live, attenuated influenza vaccine

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.

Live, attenuated influenza vaccine (called "LAIV") is a nasal spray vaccine that may be given to non-pregnant people **2 through 49 years of age.**

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:

- Is **younger than 2 years or older than 49 years** of age
- Is **pregnant**. Live, attenuated influenza vaccine is not recommended for pregnant people
- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Is a **child or adolescent 2 through 17 years of age who is receiving aspirin or aspirin- or salicylate-containing products**
- Has a **weakened immune system**
- Is a **child 2 through 4 years old who has asthma or a history of wheezing** in the past 12 months
- Is **5 years or older and has asthma**
- Has **taken influenza antiviral medication** in the last 3 weeks
- **Cares for severely immunocompromised people** who require a protected environment
- Has other **underlying medical conditions** that can put people at higher risk of serious flu complications (such as **lung disease, heart disease, kidney disease**

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

like diabetes, kidney or liver disorders, neurologic or neuromuscular or metabolic disorders)
- Does **not have a spleen**, or has a **non-functioning spleen**
- Has a **cochlear implant**
- Has a **cerebrospinal fluid leak** (a leak of the fluid that surrounds the brain to the nose, throat, ear, or some other location in the head)
- Has had **Guillain-Barré Syndrome** within 6 weeks after a previous dose of influenza vaccine

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

For some patients, a different type of influenza vaccine (inactivated or recombinant influenza vaccine) might be more appropriate than live, attenuated 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.

4. Risks of a vaccine reaction

- Runny nose or nasal congestion, wheezing, and headache can happen after LAIV vaccination.
- Vomiting, muscle aches, fever, sore throat, and cough are other possible side effects.

If these problems occur, they usually begin soon after vaccination and are mild and short-lived.

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.

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

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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

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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.

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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.

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