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. If your child is uninsured, there is no cost to you for the flu vaccine. If your child is covered by insurance, including TennCare and private insurance, the County Health Department will file a claim with the insurance plan and receive reimbursement directly from the insurance plan. There is no out of pocket cost to you for the flu vaccines provided during this school flu vaccination clinic.

Health Department nurses will vaccinate children and school staff using one of two types of vaccine: 1) Injectable (shot). 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 both sides of the attached flu vaccine 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 Consent Form and Influenza Immunization Documentation Form

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

**PLEASE PRINT**

School: ___________________________ Home Room Teacher: ___________________________ Grade: ___________________________

Student: Last Name: ___________________________ First Name: ___________________________ MI: ___________________________

SEX: ☐ M  ☐ F  DOB: / /  Current Age: _______ Child's SSN: ___________________________

RACE: ☐ Asian  ☐ Black  ☐ Native American  ☐ Pacific Islander  ☐ White  ☐ Other  ETHNICITY: Hispanic ☐ Y ☐ N

Address: ___________________________ City: ___________________________ State: ___________________________ Zip: ___________________________

Parent/Guardian: Last Name: ___________________________ First Name: ___________________________ MI: ___________________________

Parent/Guardian Home Phone: ( _______ )  First Name: ___________________________ Cell Phone: ( _______ )

---

ALL QUESTIONS MUST BE COMPLETED BY CHECKING YES OR NO IN ORDER FOR THE STUDENT TO RECEIVE A FLU VACCINE

The Nurse giving the vaccination will review the information on vaccination day.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Has your child ever received a flu vaccine? When?</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Has your child received at least 2 seasonal Influenza (flu) vaccine doses since July 2019?</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Has your child ever had a serious reaction to the flu vaccine in the past? If yes, please explain.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Does your child have any allergies to food or medicine? If yes, please list.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Does your child have an allergy to any component of the flu vaccine?</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Has your child ever had Gullain-Barre' syndrome?</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Has your child received any other vaccinations in the past 4 weeks?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Name of Vaccine(s):</td>
<td>Date Given:</td>
</tr>
<tr>
<td></td>
<td>Where:</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>In the past 12 months, has a healthcare provider told you that your child had wheezing or asthma? (If yes, the live virus vaccine is not recommended for children ages 2 through 4 years)</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Does your child have a long term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem?</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>In the past 3 months, has your child taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or an alkancer drug; or have they had radiation treatments?</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Does your child live with or expect to have close contact with a person whose immune system is severely compromised so they have to live in a protective environment, such as an isolation ward for a bone marrow transplant?</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Is your child or teen (2 years through 17 years of age) receiving aspirin therapy or aspirin containing therapy?</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Is your child receiving any prescription medications to prevent or treat flu? If yes please list</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Is your child pregnant or does she expect to be pregnant within the next month?</td>
<td></td>
</tr>
</tbody>
</table>

Additional Notes:

Request for Administration of Influenza Vaccine for the above named recipient: I will receive information about the vaccine and special precautions on the Vaccine Information Sheet prior to my child receiving the vaccine and on the day of vaccination. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine 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.

I understand that this document will be given to and retained by the public health department. 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 give consent to bill TennCare and/or private insurance for the service provided.

This Consent Form is valid for administration of Influenza vaccinations for six (6) months. It may be used to administer a second dose of Influenza vaccine, If needed. I understand that I should report any changes of the above information to the health department prior to vaccination.

Parent/Guardian Signature: ___________________________  PLEASE COMPLETE BACK OF FORM  Date: ___________________________

---

PH-4205 (Rev. 05/2019)  RDA150
PARENTS: Please answer questions below for all students under age 19 yrs to determine if your child might be eligible for the Vaccine for Children (VFC) program.

Does your child have CoverKids or any type of private medical insurance? If yes, please complete the insurance information below:

Name of Insurance Plan: ___________________________  Does insurance cover vaccines?  YES   NO
Policy Number: ___________________________  Group Number: ___________________________
Name of Subscriber: ___________________________  Member ID: ___________________________
Address To File Claims: ___________________________  Birth Date of Subscriber: ___________________________
(from back of card)

Does your child have TennCare? If yes, circle the health plan and provide ID number:

BlueCare/TennCare Select  United Health Care  Amerigroup
TennCare ID#______________________________

If your child has private insurance and TennCare, please complete private insurance information above also.

Is your child uninsured?  YES  NO
Is your child an American Indian or Alaska Native?  YES  NO

**Nursing Immunization Documentation**

**AREA FOR OFFICIAL USE ONLY**

VFC Eligible:  YES  NO

**AREA FOR OFFICIAL USE ONLY**

#1  Manufacturer:  □ Sanofi  □ Seqirus  □ GSK  □ AstraZeneca  □ Other ___________________________
VIS Date: _______ / _______ / _______
Lot number: ___________________________
Date Given: ___________________________
Site administered:  □ Right Deltoid  □ Left Deltoid  □ Intranasal
Signature ___________________________
Signature above indicates immunization given according to PHN Protocol
Provider Number: ___________________________

#2  Manufacturer:  □ Sanofi  □ Seqirus  □ GSK  □ AstraZeneca  □ Other ___________________________
VIS Date: _______ / _______ / _______
Lot number: ___________________________
Date Given: ___________________________
Site administered:  □ Right Deltoid  □ Left Deltoid  □ Intranasal
Signature ___________________________
Signature above indicates immunization given according to PHN Protocol
Provider Number: ___________________________
VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): What you need to know

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.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
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/
STATE OF TENNESSEE DEPARTMENT OF HEALTH

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

OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

The Department of Health’s workforce is required by 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 condition, the provision of health care to you, and payment for health care. We are required to give you a notice of our privacy practices for the information we collect and keep about you.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand 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 you receive. For example, we may need to tell your health insurance about a treatment you need 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 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 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.
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 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 believe there is an error or missing information in your record, 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 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.** You have a right to be notified 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 TDH 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 FILE A COMPLAINT 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  
HHS Building, Room 509H  
Washington, DC 20201  
TTY 888-788-4999  
877-696-6775