



Georgia Department of Public Health
SOUTHWEST HEALTH DISTRICT

Mitchell County Health Department

88 W. Oakland Ave.
 Camilla, GA 31730
 (229) 355-3081 Fax (229) 355-3082 Emergency 888-430-4599
www.southwestgeorgiapublichealth.org

Dear Parents/Guardians:

This influenza (flu) season we would like to help protect our student body by providing flu vaccines during school hours. Mitchell County Health Department will be offering flu vaccines in schools. If your child has health insurance, we will bill your insurance provider. Please send a copy of the insurance card with the attached form back to your child's school.

The following vaccines will be available:

- ❖ **Inactivated Influenza Vaccine (IIV):** an influenza vaccine that is given as a shot. Inactivated influenza vaccine will be quadrivalent (IIV4).

For more information on the vaccine types above, please see the Vaccine Information Statement (VIS) attached.

Influenza Vaccination Clinic Date and Location:

October 28, 2020	Baconton Community Charter School
Date	School Name

If you would like to have your child vaccinated during the above school based flu clinic please:

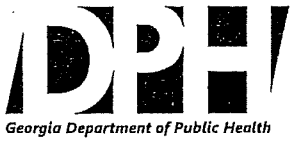
1. Review the Vaccination Information Statement (VIS).
2. Sign, date, and return the attached Consent Form to your child's teacher on 09/29/2020
3. *Note: If the consent form is not signed, dated and returned, your child(ren) will not be immunized.*

Children up to 8 years of age may need a second dose approximately one month after the first dose. We will provide the second dose during Visit 2.

We thank you in advance for helping to keep our students safe and healthy. If you have any questions about the influenza vaccine, please feel free to contact the school nurse or your health care provider.

Please note that participation and receipt of influenza vaccine through this program is completely voluntary. The health care provider for your child can answer your questions about the influenza virus and will be able to vaccinate your child against seasonal influenza. For additional information please visit the CDC influenza websites at <http://www.cdc.gov/flu/> and <http://www.cdc.gov/flu/parents>.

2020-2021 School Based Flu Program



2020-2021 School Based Influenza Vaccine Consent Form Mitchell County Health Department

Section 1: Information about Student to Receive Influenza Vaccine (please print)

STUDENT'S NAME (Last)		(First)	(M.I.)	SCHOOL NAME: Baconton Community Charter School	
STUDENT'S DATE OF BIRTH (mm/dd/yyyy)		STUDENT'S AGE	GENDER: M / F	TEACHER	GRADE
ETHNICITY (Please Circle) Not Hispanic/Latino Hispanic Latino		RACE (Please Circle) African American, White, Hispanic or Latino, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific Islander, Other		PARENT/ LEGAL GUARDIAN'S NAME	
HOME ADDRESS			PARENTAL/ GUARDIAN PHONE NUMBER(S)		
CITY		STATE	ZIP CODE	PARENTAL/ GUARDIAN E-MAIL	
INSURANCE INFORMATION; Do you have Insurance that covers vaccines? <input type="checkbox"/> Yes / <input type="checkbox"/> No Please check health insurance provider below: <input type="checkbox"/> Aetna <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> PeachCare <input type="checkbox"/> <input type="checkbox"/> Cigna <input type="checkbox"/> United Healthcare <u>SEND COPY OF</u> <u>CARD</u>				Provide the insurance information for the provider selected & attach a copy of the insurance card to this form Policy Holder Name _____ Group# _____ Member ID # _____	

Section 2: Medical Information: The following questions will help us to determine if this student can receive the influenza vaccine. *Please circle Yes or No for each question.

1. Has the student received any vaccines in the last four weeks? If yes, please list:	Yes	No
2. When was the student last vaccinated for flu?	DATE:	
3. Has the student ever had a serious reaction to eggs?	Yes	No
4. Has the student ever had a serious reaction to any influenza vaccine?	Yes	No
5. Does the child use an inhaler or receive breathing treatments for asthma or a wheezing condition?	Yes	No
6. Is the student on long term aspirin or aspirin-containing therapy (For example: does the student take aspirin everyday)	Yes	No
7. Does the student have any significant or chronic (long term) health conditions? (For example: diabetes, sickle cell disease, heart conditions, lung conditions, seizure disorders, cerebral palsy, muscle or nerve disorders)	Yes	No
8. Is the person to be vaccinated receiving influenza antiviral medications?	Yes	No
9. Does the student have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	Yes	No
10. Is the student or could the student be pregnant?	Yes	No
11. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No

Section 3: Consent: The vaccine consent form includes options allowing you to either accept or refuse the vaccination for your child. If you refuse, the vaccination will not be given to your child. If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.

I GIVE CONSENT to the Mitchell County Health Department for the student named above to receive the influenza vaccine. I acknowledge that the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statements for the influenza vaccines and the NOTICE of PRIVACY POLICY FORM. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine that will be given to the student that I am authorized to represent. I understand that participation and receipt of the influenza vaccine through this program is completely voluntary. By signing below, I give permission for the student listed above to receive the intranasal or injectable influenza vaccine.

Signature of Parent/Legal Guardian: _____ Date: _____

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I DO NOT GIVE CONSENT to the Mitchell County Health Department and/or its staff, for the student named above to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian: _____ Date: _____

FOR CLINIC USE ONLY

Influenza Vaccine: Inactivated Quadravalent	Adm Route:	Date Dose Administered:	Mfg:	Lot #	Exp Date:	VIS Date:	Signature of Nurse: Date: _____
FluLaval	IM: LA/RA	/ /			/ /	08/15/2019	Entry Clerk Initial: Date: _____
Fluzone							

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 of age and older, pregnant women, 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.

Each 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 vaccine

CDC recommends everyone 6 months of age 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 three or four viruses that are 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 vaccine 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 to a future visit.

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

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- 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 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. 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. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call 1-800-232-4636 (1-800-CDC-INFO) or
 - Visit CDC's www.cdc.gov/flu

Vaccine Information Statement (Interim)
**Inactivated Influenza
Vaccine**



Office use only

8/15/2019 | 42 U.S.C. § 300aa-26



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 IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Georgia Department of Public Health and the County Board of Health (CBOH) to maintain the privacy of your health information, inform you of its legal duties and privacy practices with respect to your health information through this Notice of Privacy Practices, notify you if there is a breach involving your protected health information, agree to restrict disclosure of your health information to your health plan if you pay out-of-pocket in full for health care services and abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this Notice at any time. The Notice will be posted on the website at www.southwestgeorgiapublichealth.org. Copies of the Notice are available upon request.

The Department of Public Health and the County Boards of Health will follow this Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment: We may use or disclose your health information to provide you with treatment or services. County Boards of Health may disclose your health information to doctors, nurses or other healthcare personnel involved in your care. For example, County Boards of Health may share your information with programs involved in your follow-up care, such as the Babies Can't Wait program. Also, the DPH Public Health Laboratory will return lab test results to the person who ordered the tests, and those results may be used for your treatment or follow-up care.

Payment: We may use or disclose your health information to bill and collect payment for the services that you receive. For example, your health insurance company may need to provide your health plan with information about the treatment you received so that it can make payment or reimbursement for services provided to you.

Health Care Operations: We may use and disclose information about you for health care operations. For example, we may review treatment and services to evaluate the performance of our staff in caring for you, and to determine what additional services should be provided.

Appointment Reminders, Follow-Up calls: We may use or disclose medical information about you to remind you of an upcoming appointment or to check on you after you have received treatment.

Individuals Involved in Your Care: Unless you tell us otherwise, we may disclose your health information to a family member, relative, or close friend who is involved in your care or assists in taking care of you. We may also disclose information to someone who helps pay for your care. We may disclose your health information to an organization assisting with disaster relief to help notify your family member, relative, or close friend of your condition, status and location.

Business Associates: We may disclose your information to contractors (business associates) who provide certain services to us. We will require these business associates to appropriately safeguard your information.

Public Health Activities: We may disclose your health information for public health activities which include: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting reactions to medications or problems with products or notifying a person of product recalls.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your medical information to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only disclose this if you agree, or when required or authorized by law or regulation.

Health Oversight Activities: We may disclose your health information to a health oversight agency that is authorized to conduct audits, investigations, inspections, licensure and other activities necessary to monitor the health care system, government programs and compliance with civil rights laws.

Judicial and Administrative Proceedings: We may disclose your health information if ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process, but only if reasonable efforts have been made to notify you of the request or to protect the health information requested.

Law Enforcement: We may release health information to law enforcement to comply with a court order, warrant, subpoena or similar process to identify or locate a suspect, fugitive, material witness or missing person about the victim of a crime in certain circumstances if we believe a death resulted from criminal conduct to report a crime occurring on our premises in emergencies, to report a crime, the location or victims of the crime, or the identity, description and location of the person committing the crime.

Research: Under certain circumstances we may use or disclose your health information for research. In most cases, we will ask for your written authorization before doing so. Sometimes, we may use or disclose your health information for research without your written authorization. In those cases, the use or disclosure of your health information without your consent will be approved by an Institutional Review Board or Privacy Board.

Coroners, Medical Examiner and Funeral Directors: We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

To Avert a Serious Threat to Health or Safety: We may use or disclose your health information, if necessary to prevent or lessen a serious and imminent threat to your safety, another person, or the general public. We will only disclose your information to a person who can prevent or lessen that threat.

National Security and Intelligence Activities and Protective Services for the President: We may disclose your health information to authorized federal officials conducting intelligence and other national security activities. We may also disclose your health information to authorized federal officials for the provisions of protective services to the President, other authorized persons, foreign heads of state or to conduct special investigations.

Military and Veterans: We may disclose the health information of Armed Forces personnel to appropriate military command authorities for the execution of their military mission. We may also disclose health information about foreign military personnel to foreign military authorities.

Inmates: If you are an inmate, we may disclose your health information to the law enforcement official or correctional institution having custody to provide you with health care, and to protect your health or safety or that of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation: We may release your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

As Required by Law: We will disclose your health information when required to do so by law.

Except in limited circumstances, we must obtain your authorization for 1) any use or disclosure of psychotherapy notes 2) any use or disclosure of your health information for marketing, and 3) the sale of your health information. If your health information has information relating to mental health, substance abuse treatment, or HIV/AIDS, we are required by law to obtain your written consent before disclosing such information. Any other use or disclosure not mentioned in this Notice will be made only with your written authorization, and you can revoke that authorization at any time. The revocation must be in writing, but will not apply to disclosures made in reliance on your prior authorization.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy your records. You must submit your request in writing to the HIPAA Privacy Officer, PO Box 283, Camilla, GA 31730, and include your name, date of birth, social security number, and the location where services were received if you received services at a local county health department. We may deny your request and in some circumstances, you may request a review of the denial.

Right to Request an Amendment of PHI: You may request that we amend information that we have about you, for as long as we keep that information. You must submit your request in writing to the HIPAA Privacy Officer, PO Box 283, Camilla, GA 31730, and include your name, date of birth, social security number, a reason that supports your request, and the location where services were received if you received services at a local county health department. Your request may be denied if 1) the information was not created by us unless the creator of the information is not available to make the requested amendment, 2) the information is not kept by us 3) the information is not available for your inspection, or 4) the information is accurate and complete.

Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date on which the accounting is requested. The accounting will not include any disclosures 1) to you or your personal representative 2) made pursuant to your written authorization 3) made for treatment, payment or business operations 4) made to your friends and family involved in your care or payment for your care 5) that were incidental to permissible uses or disclosures or your health information 5) of limited portions of your health information that excludes identifiers 7) made to federal officials for national security and intelligence activities, and 8) to correctional institutions or law enforcement officers about inmates. To request an accounting of disclosures, submit your request in writing to the HIPAA Privacy Officer, PO Box 283, Camilla, GA 31730. Please include your name, date of birth, social security number, the period for which the accounting is being requested, and the location where services were received if you received services at a local county health department.

Right to Request Restrictions: You may request that we restrict the way we use and disclose your health information for treatment, payment or health care operations. You may also request that we limit how we disclose your health information to a family member, relative or close friend involved in your care or payment for your care. We are not required to agree to your request, but if we do, we will comply with your request unless you need emergency treatment and the information is needed to provide the emergency treatment. We may terminate our agreement to a restriction once we notify you of the termination. To request a restriction on the use or disclosure of your health information, please send your request in writing to the HIPAA Privacy Officer, PO Box 283, Camilla, GA 31730. Please include your name, social security number, and date of birth, what information you want to limit, to whom you want the limitation to apply, and the location where services were received if you received services at a local county health department.



Mitchell County Board of Health

Form GC-09013B

Right to Request Confidential Communications: You may make reasonable requests to receive communications of your health information by alternate means or at alternate locations. For example, you may ask to be contacted only by mail, and not by phone. To request confidential communications, please send your request in writing to the HIPAA Privacy Officer, PO Box 283, Camilla, GA 31730. Please include your name, social security number, date of birth, how you would like to be contacted, and the local county health department where you received services.

Right to Receive a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice, which you may request at any time. You may obtain a paper copy by writing to the HIPAA Privacy Officer, PO Box 283, Camilla, GA 31730.

COMPLAINTS

If you believe that your privacy rights have been violated, you may send a written complaint to the HIPAA Privacy Officer, PO Box 283, Camilla, GA 31730. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

For further information you may contact the HIPAA Privacy Officer at 229-355-3081.

THIS NOTICE IS EFFECTIVE August 1, 2017.

HIPAA SECURITY OFFICER

The HIPAA Security Officer may also be reached at 229-355-3081 or by writing to:

HIPAA Security Officer
PO Box 283
Camilla, GA 31730