GOSNELL SECONDARY SCHOOL
600 Highway 181
Gosnell, AR 72315
Phone: (870) 532-4015
Fax: (870) 532-4035

Steven Milligan, Principal
Keelen Newsom, HS Asst. Principal
Phillip Cook, JH Asst. Principal
Sandy Brown R.N. Secondary Nurse

Dear Parent,

We will be having our annual flu clinic at the school again this year. Please read and fill out the Medical History consent form, sign at the bottom right side and turn page over and fill out the Patient Information section (student information). We also need for you to complete the (FERPA) form. Please print your name and your child's name then sign and date the form.

The date of the flu clinic will be on Friday October 11th. We need to have all of the permission forms back as soon as possible but NO later than **October 4th 2019.** We need to have an accurate count in order to let the Health Department know how many doses our school will need. If you have any questions please call 532-4015.

Please **complete**: 1. **Second page** of this letter **(FERPA)** form for school.
2. The **last page** in this package **FRONT** and **BACK** for MCHD.
3. Return form to school nurse.

[redacted] forms MUST be completed in order for your child to get vaccine.

Thank you,
S.Brown R.N.
Secondary School Nurse

Gosnell High School

School Immunization Clinic

School Year 2019-2020

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99)

I, _____, give permission for my child, _____ Grade _____,
Print Parent/Guardian Name **Student Print First and Last Name**

to participate in the School Immunization Clinic. Check all that apply:

- ☐ Influenza
- ☐ Tetanus, Diphtheria and acellular Pertussis (Tdap)
- ☐ Diphtheria, Tetanus and acellular Pertussis (DTaP)
- ☐ Measles, Mumps and Rubella (MMR)
- ☐ Polio
- ☐ Haemophilus influenza type B (HIB)
- ☐ Hepatitis B (Hep B)
- ☐ Varicella (Chicken Pox)
- ☐ Human Papillomavirus (HPV)
- ☐ Meningococcal
- ☐ Hepatitis A (Hep A)
- ☐ Prevnar
- ☐ PPD
- ☐ Other_____

Parent/Guardian Signature_____Date Signed _____

ARKANSAS DEPARTMENT OF HEALTH
INFLUENZA SEASON – IMMUNIZATION CONSENT FORM

[redacted] ADH Clinic Code: _____ School LEA #: _____ Date Of Service: _____

School Name: _____ School Grade: _____

Person Receiving Vaccine:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

*If YES and further guidance is needed, notify the Regional CDNS	*YES	NO	
Do you have a fever today? (If you have a fever on the day of the clinic it may prevent you from receiving the influenza vaccine.)			If any answer is YES, you may not be able to receive the flu vaccine.
Have you ever had a serious reaction to a previous dose of flu vaccine, such as difficulty breathing, swelling of eyes or lips, wheezing, or immediate nausea or vomiting? Do you have a severe allergy to any foods or medications? (i.e., gelatin, gentamicin or neomycin)			
Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
Are you younger than 2 years? ☐ Yes ☐ No Are you older than 49 years? ☐ Yes ☐ No			If any answer is YES, you can receive only the injectable flu vaccine (shot), not the intranasal flu vaccine (flu mist).
Are you pregnant?			
Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? For a child 2 through 4 years: Have you been told by a health care provider that your child had wheezing or asthma in the past 12 months?			
Are you on long-term aspirin or aspirin-containing therapy? Do you take aspirin every day? Have you received influenza antiviral medications within the last 48 hours? (Tamiflu, Relenza, Rapivab, Xofluza)			
Have you received any of these vaccines in the last 28 days? Measles, mumps, rubella (MMR) ☐ Yes ☐ No Varicella (chickenpox) ☐ Yes ☐ No Intranasal influenza vaccine (Flu Mist) ☐ Yes ☐ No			
Do you have a severely weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer, rheumatoid arthritis, Crohn's disease, psoriasis, or radiation treatments)?			
Do you have close contact with a person who needs care in a protected hospital environment (for example, someone who has recently had a bone marrow transplant)?			
For parents NOT attending flu clinic with their child: If you answered No to all of the above questions, your child may receive either the flu shot (injectable) or flu mist (nasal spray). Please mark your preference of vaccine type below. **If your preferred vaccine type is not available or marked, the nurse will give what is available unless you indicate otherwise.** ☐ **Flu Shot** ☐ **Flu Mist** ☐ **No Preference** ☐ **Do not give if my preference is not available** **Child's Homeroom Teacher:** _____ **(For school clinic use)**			
• NOTE: Children aged 6 months through 8 years may require a second dose. Contact your health care provider or your ADH Local Health Unit in four weeks for more information.			

2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Arkansas Department of Health's Privacy Notice is on the website www.healthy.arkansas.gov, posted and available at the clinic site, or accompanies this form.
Then sign in the box at right.

Please sign here

My signature below indicates I have read, understand and agree to section **2. Release and Assignment** of the Influenza Season -- Immunization Consent Form. and **Vaccine Information Statement (VIS).**

Signature of Patient/Parent/Guardian:

_____ date _____

RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine and the Live Attenuated Intranasal Vaccine (Flu Mist) and understand the risks and benefits. To read the Vaccine Information Statement (VIS) for each vaccine visit the website to view current VIS: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html**
- **I give consent to the State/Local Health Department and its staff for the individual named below to be vaccinated with the flu vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Arkansas Department of Health's Privacy Notice.**
- **I understand that information about this flu vaccination will be included in the Arkansas Department of Health's Immunization Registry.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to the Arkansas Department of Health.**
- **I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.**
- **I agree that the photocopy of this form may be used instead of the original.**

3. PATIENT INFORMATION:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Date of Birth: ☐☐/☐☐/☐☐☐☐ **Gender:** ☐ Male ☐ Female **Phone #:** _____

Street Address: _____ **P.O. Box** _____ **Apt. No.** _____

City: _____ **State:** _____ **Zip Code:** ☐☐☐☐☐

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African-American ☐ American Indian/Alaska Native
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

4. INSURANCE STATUS (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

☐ **Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐☐

☐ **Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Insurance Company Name:** _____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER Information:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Policy Holder Date of Birth: ☐☐/☐☐/☐☐☐☐ **Email Address:** _____

Policy Holder's Employer Name: _____

Flu Vaccine Administration

SHOT CODE:

☐ 70: Quadrivalent (P-F) ≥ 6 months ☐ 39: Quadrivalent Intranasal vaccine (P-F) 2 - 49 years

	Route	Site Code	Dosage mL.	MFG Code	Lot Number
Flu Vaccine	☐ IM ☐ Intranasal				

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

MFG Codes: SKB = GlaxoSmithKline, PMC = Sanofi, MED = MedImmune, SEQ = Seqirus

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____/_____/_____

FORM 4056 Revised 7/03/2019