



Georgia Department of Public Health

Southwest Health District

Thomas County Health Department

484 Smith Avenue Thomasville, Georgia 31792
P. O. Box 148 Thomasville, Georgia 31799
(229) 226-4241 Fax (229) 379-3520 Emergency (888)430-4590

January 1, 2019

Dear Parents and Caregivers,

We are pleased to announce that the Thomas County Health Department will be coming to your child's school during the month of January to offer the flu vaccine.

There will be no out-of-pocket cost for your child to receive the vaccine given during the school flu clinics. However, we will need to obtain your insurance information on the consent form provided. If you have insurance, your insurance provider will be charged.

If you would like your child to get vaccinated at the school flu clinic, please review the enclosed informational materials, including the Vaccination Information Statement (VIS) for the flu vaccine. Sign and return the enclosed Parental Consent Form to your school nurse. If the consent form is not signed, dated, and returned by due date on the form your child will not be vaccinated.

Please understand that participation and receipt of the influenza vaccine through this program is completely voluntary.

We would like to thank you in advance for assisting us in keeping all our students safe and healthy. If you have any questions regarding the flu vaccine, please do not hesitate to contact the school nurse, Thomas County Health Department, or your healthcare provider.

Sincerely,

Handwritten signature of Carolyn Simmons, RN, BSN

Carolyn Simmons, RN, BSN
Director
Thomas County Health Department

BAKER ~ CALHOUN ~ COLQUITT ~ DECATUR ~ DOUGHERTY ~ EARLY

GRADY ~ LEE ~ MILLER ~ MITCHELL ~ SEMINOLE ~ TERRELL ~ THOMAS ~ WORTH



We Protect Lives.



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Attention Parents / Guardian:

For your child to **participate** in the school flu clinic we must have the enclosed parental consent form completed, signed and returned to your child's school.

RETURN BY:

January 15, 2018

Flu Shot Date by school:

Bishop Hall/Renaissance Center/ Pathways – January 23rd

Garrison Pilcher/ Cross Creek – January 30th

Thomas County Middle School/Thomas County Central High School – January 30th

Hand in Hand – January 31st

BAKER ~ CALHOUN ~ COLQUITT ~ DECATUR ~ DOUGHERTY ~ EARLY

GRADY ~ LEE ~ MILLER ~ MITCHELL ~ SEMINOLE ~ TERRELL ~ THOMAS ~ WORTH



We Protect Lives.



THOMAS COUNTY HEALTH DEPARTMENT
Southwest Health District

Patient #: _____

2018-2019 Influenza Vaccine Consent Form/School-Based Flu Clinics

STUDENT'S NAME (Last)		(First)	(M.I.)	SCHOOL NAME:	
STUDENT'S DATE OF BIRTH (mm/dd/yyyy)		STUDENT'S AGE	GENDER: M / F		TEACHER
ETHNICITY (Please Circle) Not Hispanic/Latino Hispanic/Latino		RACE (Please Circle) African American, White, 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	ALLERGIES		
INSURANCE INFORMATION: Do you have Insurance that covers vaccines? Yes / No Check health insurance provider below. (You will not be charged for this vaccine.) <input type="checkbox"/> BCBS <input type="checkbox"/> AETNA/Coventry <input type="checkbox"/> Cigna <input type="checkbox"/> United Healthcare Policy # _____ Group # _____ <input type="checkbox"/> Medicaid / Wellcare / Peachstate / Amerigroup / CareSource / Peachcare # _____ <input type="checkbox"/> No Insurance/Other: _____					

Section 2: Medical Information. The following questions will help us to know if this student can receive the 2018-2019 Influenza Vaccine. **Please circle Yes or No for each question.*

1. Has the student ever had a serious reaction to any influenza vaccine?	Yes	No
2. Has the student child ever had a serious reaction to eggs?	Yes	No
3. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No
4. Is the student allergic to latex?	Yes	No

Section 3: Consent:

If you selected YES TO QUESTION 1 - 3 in section 2 your child WILL NOT be able to receive INJECTABLE flu vaccine at school.
 Contact your healthcare provider regarding flu vaccine for your child

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE: *By signing below, I give permission for the student named above to receive the 2018-2019 Influenza vaccine.* I acknowledge the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statements (VIS) dated 08/07/2015 for the influenza vaccines and I understand the NOTICE of PRIVACY PRACTICES and have been provided with a copy for my review. 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 I am authorized to represent. I understand 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 Injectable Influenza Vaccine. **The consent form will provide permission to vaccinate for both doses, if needed.** (See VIS) If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.

Signature of Parent/ Legal Guardian: _____ Date: _____

Health Department Staff Use Only

Type Vaccine	Date Administered	Mfg. /Lot#/Exp. Date	Administration Route	Nurse Signature	GRITS Check:
1 st Inactivated: VFC /CP	1 st _____	1 st _____	IM / LD/LM RD/RM	1 st _____	Date and Verified By: _____
2 nd Inactivated: VFC/CP	2 nd _____	2 nd _____	IM / LD/LM RD/RM	2 nd _____	
Allergy Status Verified	Right Vaccine/No contraindications	Right Formulation for Patient's Age	Right Patient/Verify @ Minimum Name and DOB	Expiration Date Valid	Right Dose/Route

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 (“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.



4 Risks of a vaccine reaction

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/

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling **1-800-822-7967**.

VAERS does 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.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- 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 website at www.cdc.gov/flu

Vaccine Information Statement
Inactivated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26

Office Use Only





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.



Thomas County Board of Health
CBOH Form GC-09013B

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 disclose 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.



Thomas County Board of Health
CBOH Form GC-09013B

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 148, Thomasville, GA 31799, 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 148, Thomasville, GA 31799, 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 of your health information 6) 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 148, Thomasville, GA 31799. 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 148, Thomasville, GA 31799. 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.

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 148, Thomasville, GA 31799. 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 148, Thomasville, GA 31799.

COMPLAINTS

If you believe that your privacy rights have been violated, you may send a written complaint to the HIPAA Privacy Officer, PO Box 148, Thomasville, GA 31799. 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.



Thomas County Board of Health
CBOH Form GC-09013B

FOR FURTHER INFORMATION

For further information you may contact the HIPAA Privacy Officer at 229-226-4241.

THIS NOTICE IS EFFECTIVE February 3, 2014.

HIPAA SECURITY OFFICER

The HIPAA Security Officer may also be reached at 229-226-4241 or by writing to:

HIPAA Security Officer
PO Box 148
Thomasville, GA 31799