Franklin County Health Department

October 10, 2016

Dear Parent/Guardian:

The Franklin County Health Department will be providing Influenza vaccinations at the schools. This year, the vaccine will, again, protect against both Seasonal Influenza and H1N1 flu. There will be no cost to the parents for this vaccination. However we will be billing insurance companies this year. **Please complete the registration form ON THE BACK OF THIS SHEET and return it to your schools as soon as possible; don't forget to answer the Medical History questions and sign for consent.** Parents/Guardians are not required to be present when their child receives the vaccination, **if they have signed the consent form in advance.**

We will **only be administering injectable flu vaccine (inactivated vaccine).** You may access the *Influenza Vaccine Information Sheet* and the *Notice of Privacy Policy* mentioned on the form, on our website, at www.fchd.org, or you may request one from your child's school.

Your child will receive their flu vaccine between October 17th and November 7th 2016.

Remember this year we need your insurance information but there will be **no** co-pays.

If you have any questions or concerns, you may contact your school nurse.

Sincerely,

Tammie Bertram, MSN, RN

Tammie Bertram, MSN, RN
Director of Nursing

Michelle Searcy, RN

Michelle Searcy, RN
School Nurse Supervisor

100 Glenn's Creek Road ● Frankfort, KY 40601 ● (502) 564-4269

PEF label

DOCUMENT#: ___________________________

HID/LOC/SITE: ___________________________

INFLUENZA VACCINE ADMINISTRATION RECORD

*****PLEASE PRINT in BLACK INK*****

SCHOOL: **HOME ROOM:**

NAME: **SOCIAL SECURITY #:** ☐☐☐-☐☐-☐☐☐☐

FIRST MIDDLE INITIAL LAST

ADDRESS:

(STREET) *(CITY)* *(COUNTY)*

☐☐☐-☐☐☐-☐☐☐☐

(STATE) *(ZIP)* *(PHONE NUMBER)*

BIRTHDATE: *(MONTH)* *(DAY)* *(YEAR)* **AGE:** ______ **SEX:** ☐ Male ☐ Female

RACE: Check ONE or MORE

☐ **(W)** White ☐ **(B)** Black or African American ☐ **(A)** Asian

☐ **(N)** American Indian or Alaska Native* ☐ **(H)** Native Hawaiian or Other Pacific Islander

ETHNICITY: Hispanic or Latino ☐ Yes ☐ No

DO YOU HAVE **MEDICAID**? ☐YES ☐NO **MEDICAID NUMBER**:

DO YOU HAVE **MEDICARE**? ☐YES ☐NO **MEDICARE NUMBER**:

DO YOU HAVE **HEALTH INSURANCE**? ☐YES ☐NO

If no insurance, the child is eligible for VFC vaccine

COMPANY NAME:

POLICY#

SUBSCRIBER NAME

GROUP#

MEDICAL HISTORY

(YES)	(NO)	
________	________	Has your child had a past history of Guillan-Barre syndrome within 6 weeks following a previous flu vaccine?
________	________	Has your child eaten eggs and had difficulty breathing (anaphylactic reaction)?
________	________	Has your child ever had **flu vaccine (flu shot or nasal mist)**?
________	________	Has your child had a fever in the past 24 hours?
________	________	Is your child taking Theophyline or Warfarin (blood thinner)?
________	________	Is your child allergic to any medicines or **latex?**

I have read or have had explained to me the information sheet:_____ ***Inactivated*** **(injection)** *influenza Vaccine, "What You Need To Know" (VIS Dated 08/07/2015)*

I understand I have access to the vaccine information sheet (VIS) and the *Notice of Privacy Policy* at www.fchd.org or I may request a copy from my child's school. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

I request that payment of authorized medical insurance benefits be made to Franklin County Health Department on my behalf or behalf of my child, for services received. I also authorize the local health department to release medical information to Medicare, Other Third Party Payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. I am aware that should Medicare refuse payment for this service, I will be responsible for the cost. If I am covered by a billable private insurance, I am aware that I may be responsible for some additional charges not covered by my plan.

X ____ **DATE:** ________________________

Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian/representative)

The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.