Instructions on filling out the 2015-2016 Student Influenza Consent Form

Please Print Clearly:

Section 1, Page 1
Please make sure your child's name and date of birth are accurate and clearly written.
Please include the name of the responsible parent or Guardian and date of birth of such.

Section 2, Page 1
It is very important that you answer the questions 1 -10 accurately. Please double check to make sure all questions are answered.

If you answered YES or left blank any question from #4 through # 10 or if your child is younger than 2 years old, your child WILL NOT receive Flu Mist, but she/he MAY RECEIVE the flu shot at his/her doctor or the Local Health Department.

Section 1, Page 2, Insurance Section
Make sure you have placed a check in one of the insurance section boxes.

If you have checked that your child has Medicaid or Virginia Premier, write the 12 digit identification number on the line provided as it appears on the insurance card. (Make sure you have 12 numbers listed.)

If your child has CoventryCares, Optima or In-Total Health, write the identification number on the line provided, (this number should be between 9-11 digits) and the name of the child as it appears on the insurance card.

If you have checked that your child has one of these participating insurances (Anthem or Piedmont, PCHP), please include the name of the insurance, the policy holder's name, date of birth of the policy holder and the insurance identification number of the policy holder as it appears on your insurance card to include the leading LETTERS if any.

The Health Department will make every effort possible to collect from your participating insurance company. However, please be aware that the Health Department **does not participate with every insurance company.** If you have a non-participating insurance the Health Department will send you a onetime statement/bill in the amount of $30.00. Payment for the Flu mist will be due within 30 days of receipt of the statement/bill from the Health Department. Please make checks payable to the Health Department or you can pay by Visa or Master Card by calling your local Health Department.
Amherst - (434)-946-9408
Appomattox – (434)-352-2313
Bedford – (540)-586-7652
Campbell – (434)-592-9550
Lynchburg –(434)-477-5974

The Flumist campaign is supported by local (city/county) money, and is only possible through insurance collections and patient payments.

2015-16 STUDENT INFLUENZA VACCINATION CONSENT FORM
LAIV ONLY

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Name: _____ (Last) _____ (First) _____ (Middle)

Health Department Use Only
CI#: _____
Encounter #: _____
Receipt #: _____

Date of Birth: ____/____/____ Age: _____ Gender: ❑ M ❑ F

If minor - parent/guardian's name: _____ (Last) _____ (First) _____ (M.I.)

Parent/Guardian's Date of Birth: ____/____/____ Parent's SSN: _____ - _____ - _____ (optional)

Address: _____ City/State: _____ ZIP: _____

Grade: _____ Home Room Teacher: _____ School: _____

IMPORTANT Parent/Guardian Phone # Home: _____ Cell: _____ Work: _____

Please check YES or NO to all of the questions below to determine if your child can receive the Intranasal Influenza Vaccine (FluMist® – "nasal spray"). The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO
1. Has your child ever had a serious allergic reaction to any component of any flu vaccine (eggs, gentamicin, gelatin, and arginine)?	❑	❑
2. Has your child ever had a serious reaction to a previous dose of flu vaccine in the past?	❑	❑
3. Has your child ever had Guillain-Barré syndrome (GBS, i.e., progressive ascending paralysis)?	❑	❑

If you answered YES to any of questions 1, 2 or 3 above about a serious allergy, reaction or GBS, flu vaccine may not be safe for your child and s/he WILL NOT receive a flu vaccine. If you answered NO to questions 1, 2 or 3, please continue below.

4. If your child is between 2 – 4 years, has a healthcare provider ever told you that your child had a wheezing or asthma within the last 12 months?	❑	❑
5. Does your child have a long-term health problem such as heart disease, kidney or liver disease, lung disease, metabolic disease (e.g. **diabetes**), or blood disorders (e.g. **anemia**)?	❑	❑
6. Does your child have a weakened immune system because of cancer, cancer treatment (e.g. x-rays or drugs), HIV/AIDS, other disorders, or medicine (e.g. high dose steroids)?	❑	❑
7. Does your child live with or expect to have close contact with a severely immunosuppressed person requiring a protective environment (e.g., an isolation room of a bone marrow transplant unit)?	❑	❑
8. Is your child taking aspirin or other aspirin-containing products?	❑	❑
9. Is your child taking any prescription medications to prevent or treat flu?	❑	❑
10. Has your child received a MMR (measles/mumps/rubella) and/or varicella (chickenpox) vaccination within the past 4 weeks?	❑	❑
11. Is your child pregnant or could she become pregnant within the next month?	❑	❑

If you answered YES or left blank any questions from # 4 through # 11 or if your child is younger than 2 years old, your child WILL NOT receive FluMist®. Please consult with your health care provider (pcp) or local health department to see if your child may receive the flu shot from there.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, your child's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

Office of Privacy and Security
Authorization for Disclosure of Protected Health Information

As the person signing this authorization, I understand that I am giving permission to the Virginia Department of Health (VDH) to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to me cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.

The original or a copy of the authorization shall be included with my child's medical record.

- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that this record will be retained until my child reaches 21 years of age.
- I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third party payer to pay any authorized benefits to VDH on my behalf.

☐ Please check box if you wish to receive a copy of the Virginia Department of Health Privacy Rights.

Insurance*: Please answer the following: This information is required for federal funding purposes for VFC vaccines.

***Note:** Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program. If your child is covered by a private health insurance plan, the Department is required by law to seek reimbursement for all allowable costs associated with the provision of the vaccine.

My child: ( ) is *not* insured (by private insurance, Medicaid, or FAMIS)
( ) is American Indian or is an Alaska Native
( ) has Medicaid - Medicaid #: _____
( ) has FAMIS - FAMIS #: _____
( ) has other insurance not listed above (specify plan name) _____
Policy ID # _____Policy holder's name_____

Attach a copy of the front & back of insurance card or provide the following information:
Insurance company address _____
Insurance company phone number_____

I understand that if my insurance does not pay, does not respond to the request for payment, or is a non-participating insurance with the Health Department, that I may receive a one-time statement/bill in the amount of $30.00, payable to the local Health Department.

CONSENT FOR CHILD'S VACCINATION: In October 2015, will your child be less than 9 years of age? No ☐ Yes ☐
Please complete the next set of questions and sign.

My child is **under 9 years of age** and:
☐has NEVER been vaccinated against the flu. **Note: Your child will require 2 doses this year.**
☐ has not been vaccinated with at least 2 doses of seasonal influenza vaccine before July 1, 2015. **Your child will require 2 doses this year.**

I have read the 2015 Vaccination Information Statements (VIS) for nasal spray. I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to get vaccinated with this vaccine. **If needed, I give my consent for my child to receive the second dose 4 weeks after the first.**

Signature of Parent or Legal Guardian: X _____ **Date:** ____/____/____

I understand that the Virginia Department of Health will not release private medical records unless authorized above or to continue care.

_____ X_____ _____
Please Print Your Name Signature Date

Please send a copy of my child's immunization record to her/his doctor at the following address:

*Doctor's Name*_____ *Mailing Address*_____ *City*_____ *State*_____ *ZIP*_____

HEALTH DEPARTMENT USE ONLY

Date	Item code	Cost type	Lot Number	Vaccine Administration Site	Provider #
		VFC Chargeable		RA LA NAS	
		VFC Chargeable		RA LA NAS	
Comments					
Provider Name/Signature and Date					