Flu shots are coming to your child's school.

- The health department will be giving flu shots in your child's school soon at no cost.
- If you want your child to get a flu shot at school...
  1. Complete the front side of the blue form.
  2. Return the blue form to your child's school.
- You will be informed when flu shots will be given at your child's school.
- Flu shots will not be given without consent.
- If you have questions, call the health department.

TN Department of Health

STATE OF TENNESSEE DEPARTMENT OF HEALTH

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 this carefully

OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

The Department of Health's workforce is required by the federal law entitled Health Insurance Portability and Accountability Act (HIPAA) to safeguard your Protected Health Information (PHI). PHI is individually identifiable information about your past, present or future health or condition; the provision of health care to you; and payment for health care. We are required to give you a notice of our privacy practices for the information we keep about you.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand health information about you is personal and we are committed to protecting this information. The Privacy Notice applies to all of your health information, including (1) records relating to your care at a health department clinic (2) health care records received by the Department of Health from another source and (3) genetic information.

We are required by law to: (1) keep your PHI confidential; (2) give you this Privacy Notice; and (3) follow the terms of the current Privacy Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND OPERATIONS

The following categories describe different ways we may use and disclose your PHI.

- **For Treatment.** We may use or disclose your PHI to doctors, nurses, nutritionists, technicians, or other health department personnel who are involved in taking care of you. We may disclose your PHI to people outside of the health department who may be involved in your medical care such as prescriptions, lab work and x-rays.
- **For Payment.** We may use or disclose your PHI to get payment or to pay for health services you receive. For example, we may need to tell your health insurance about a treatment you need to obtain prior approval or to determine whether your insurance will pay for the treatment.
- **For Health Care Operations.** We may use of disclose your PHI for Department of Health's operations. This is necessary to manage the Department's programs and activities. For example, we may use PHI to review our services, programs and/or the quality of care we provide you.
- **Appointment Reminders.** We may use your PHI to contact you as a reminder that you have an appointment for treatment or services.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR PERMISSION

The law provides that we may use of disclose your PHI from our records (even after your death) without your permission in the following circumstances:

- **As Required By Law.** We will disclose medical information about you when required to do so by law, to investigate reports or abuse or neglect, and to report the incident to the appropriate enforcement agency.
- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the state and federal government to monitor the health care delivery system in Tennessee.
- **As Public Health Risks.** We may disclose PHI about you for public health activities. These activities may include the reporting of births and deaths and the tracking, prevention, or control of certain diseases, injuries, and disabilities.
- **Research.** In certain circumstances, and under supervision of an institutional review board, we may disclose PHI to assist medical research.

Department of Health, Authorization No. 343513, 300,000copies, This public document was promulgated at a cost of $0.01 per copy. January 2016 DH-0113
ED #1000080566

- **To Avert a Serious Threat to Health or Safety.** We may use or disclose your PHI if necessary, to prevent a serious threat to you or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **For Specific Government Functions.** We may disclose PHI to law enforcement, to government benefit programs relating to eligibility and enrollment, and for the interest of national security.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** In most cases, you have the right to look at or get copies of your paper records and your electronic records. You must make the request in writing. You may be charged a fee for the cost of copying your records.
- **Right to Amend.** If you believe there is a mistake or missing information in our record of your PHI, you may ask us to correct or to add to your record. Your request me be made in writing and you must provide a reason that supports your request. We may deny your request under certain circumstances. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response you provide, appended to your PHI.
- **Right to Know What Health Information We have Released.** You have the right to ask for a list of disclosures made of your PHI made on or after April 14, 2003 for purposes other than those listed in the Privacy Notice. You must request this list in writing and state the period of time the list should cover for a period of no longer than six (6) years. The first list you request within a twelve (12) month period will be free.
- **Right to Request Restrictions.** You have the right to ask us to limit how your PHI is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom the limits apply. You have the right to restrict disclosures to a health plan for services which you fully paid for out of pocket.
- **Right to Confidential Communications.** You have the right to ask that we communicate with you in a certain way or at a certain place. For example, you may ask us to send information to your work address instead of your home address. You must make your request in writing. You will not have to explain the reason for your request. We will honor all reasonable requests.
- **Right to Authorize Release of Information.** Other releases of your PHI can be made only if you request it and you can change your authorization at any time.
- **Right to be Notified of Information.** You have a right to be notified in the event of a breach of unsecured PHI.
- **Right to a Paper Copy of This Notice.** You have a right to a paper copy of this notice any time, even if you have agreed to receive this notice electronically. You may obtain a copy of this notice at our website listed below. To obtain a paper copy of this notice, contact the TDH Privacy Officer listed below. We reserve the right to change our privacy practices and this notice at any time. We will post a copy of the current notice in all our office and at the department's website.

HOW TO GET MORE INFORMATION OR FILE A COMPLAINT ABOUT OUR PRIVACY

If you have any questions about this notice, please contact the HIPAA PRIVACY OFFICER listed below. If you believe we have violated your privacy rights, you may file a written complaint with either of the agencies listed below. You will not be affected by filing a complaint.

HIPAA Privacy Officer
TN Department of
Health Compliance
Office
5th Floor, Andrew
Johnson Tower
710 James Robertson
Parkway
Nashville, TN 37243
(615) 253-5637
877-280-0054 Fax:
(615) 253-3926
Email:
privacy.health@tn.gov

Sectary
U.S. Department of Health & Human Services
200 Independence Ave. SW
HHH Building, Room 509H
Washington, DC 20201
TTY 886-788-4989
877-696-6775

Department of Health, Authorization No. 343513, 300,000copies, This public document was promulgated at a cost of $0.01 per copy. January 2016 DH-0113
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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 and older, pregnant people, 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.

In an average 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 vaccines

CDC recommends everyone 6 months 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 the influenza viruses believed to be 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 vaccination 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 until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

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.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- 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 members 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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. 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.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- 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**.

Tennessee Department of Health School Located Influenza Vaccination Project
Student Consent Form & Influenza Documentation Form

If you want a Flu Vaccination given to your child, COMPLETE THE INFORMATION ON THE FRONT AND BACK OF THIS FORM AND SIGN. If NO, stop here and discard the form

Please Print

School:		Home Room Teacher:	Grade:
Student Last Name:		First Name:	MI:
Sex: ❑M ❑F	DOB: / /	Current Age:	
Race: ❑Asian ❑Black ❑Native American ❑Pacific Islander ❑White ❑Other:		Ethnicity: Hispanic ❑Yes ❑No	
Address:	City:	State:	Zip:
Parent/Guardian Last Name:		First Name:	MI:
Parent Guardian Home Phone:		Cell Phone:	

ALL QUESTIONS MUST BE COMPLETED BY CHECKING YES OR NO IN ORDER FOR THE STUDENT TO RECEIVE A FLU VACCINE
The Nurse giving the vaccination will review the information on vaccination day.

1.	Has your child ever received a flu vaccine?	❑Yes	❑No
	If yes, when:		
2.	Has your child received at least 2 seasonal influenza (flu) vaccine doses prior to last July 1?	❑Yes	❑No
3.	Has your child ever had a serious reaction to the flu vaccine in the past?	❑Yes	❑No
	If yes, when:		
4.	Does your child have any allergies to food or medicine?	❑Yes	❑No
	If yes, list allergies:		
5.	Does your child have an allergy to any components of the flu vaccine?	❑Yes	❑No
6.	Has your child ever had Guillain-Barre´ syndrome? (Muscle weakness, reflex loss and numbness or tingling in any part of the body	❑Yes	❑No
7.	Has your child received any other vaccinations in the past 4 weeks?	❑Yes	❑No
	Name of vaccine(s): Where: Date Given:		
8.	In the past 12 months, has a healthcare provider told you that your child had wheezing or asthma?	❑Yes	❑No
9.	Does your child have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes) or anemia or another blood disorder?	❑Yes	❑No
10.	Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	❑Yes	❑No
11.	In the past 3 months, has your child taken medications that weaken the immune system, such as cortisone, prednisone or anticancer drugs; or have they had radiation treatment?	❑Yes	❑No
12.	Does your child live with or expect to have close contact with a person whose immune system is severely compromised, and who must be in a protective isolation, (e.g., such as isolation room for a bone marrow transplant?	❑Yes	❑No
13.	Is your child receiving aspirin therapy or aspirin containing therapy?	❑Yes	❑No
14.	Is your child receiving any prescription medications to prevent or treat flu?	❑Yes	❑No
	If yes, list:		
15.	Is your child pregnant or does she expect to be pregnant within the next month?	❑Yes	❑No

Additional notes:

Request for Administration of Influenza Vaccine for the above named recipient: I received information about the vaccine and special precautions on the Vaccine Information Sheet prior to my child receiving the vaccine and on the day of vaccination. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Tennessee Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

I understand that this document will be given to and retained by the Tennessee Department of Health. I give permission for my child's school to retain a copy if needed. I acknowledge that I have been given the Department of Health's Notice of Privacy Practices.
This Consent Form is valid for administration of influenza vaccinations for twelve (12) months. It may be used to administer a second dose of influenza vaccine, if needed. I understand that I should report any changes of the above information to the health department prior to vaccination.

Parent/Guardian Signature: _____ Date: _____

PLEASE COMPLETE BACK OF FORM

Parents: Please answer questions below for all students under age 19 yrs to determine if your child might be eligible for the Vaccine for Children (VFC) program.

Does your child have TennCare, CoverKids, or any type of private medical insurance? ❑Yes ❑No

If yes, please complete the insurance information below:

Patient's SSN: _____

TennCare ID#:_____

Please circle your TennCare insurance provider
BlueCare/TennCare Select United Healthcare Amerigroup

Name of Insurance Plan:_____ Does insurance cover vaccines? ❑Yes ❑No

Policy Number:_____ Group Number:_____

Name of Subscriber: _____ Member ID:_____

Address To File Claims *(Back of card)*:_____ Birth Date of Subscriber: _____

AREA FOR OFFICIAL USE ONLY				
Nursing Immunization Documentation				
VFC Eligible:	❑Yes ❑No			
❑The Child's identity has been confirmed by TDH staff (staff initials) with a minimum of two of the following:				
	❑Child states name	❑Child states DOB	❑Child states parent name on form	❑Child states address on form
❑Child unable to provide 2 identifiers to TDH Staff. The child's identity has been confirmed by responsible school personnel below:				
	Name:		Signature:	
	Title:			
AREA FOR OFFICIAL USE ONLY				
#1	Manufacturer:	❑Sanofi	❑GSK	❑Seqirus
		❑AstraZeneca	❑Other:	
VIS Date: / /	Site Administered:	❑Right Deltoid 0.5mL IM	❑Left Deltoid 0.5mL IM	❑Intranasal 0.2mL
Lot number:	Signature:_____ *Signature above indicates immunization given according to PHN protocol*			
Date Given: / /	Provider number:			
#2	Manufacturer:	❑Sanofi	❑GSK	❑Seqirus
		❑AstraZeneca	❑Other:	
VIS Date: / /	Site Administered:	❑Right Deltoid 0.5mL IM	❑Left Deltoid 0.5mL IM	❑Intranasal 0.2mL
Lot number:	Signature:_____ *Signature above indicates immunization given according to PHN protocol*			
Date Given: / /	Provider number:			