School System — Mobile County (Day 3) — Wednesday 11/06/2024

2021-2022 Flu Doses 1900 — 3.61% Participation Rate
2022-2023 Flu Doses 1631 — 3.16% Participation Rate
2023-2024 Flu Doses 1731 — 3.42% Participation Rate
Lead Nurse - Barbara Smith — bsmith3@mcpss.com
Lead Nurse - Pamela Smith — psmith1@mcpss.com

Health Hero Team 5 ________

1. Old Shell Road Magnet 3160 Heather St. Mobile (251) 221-1557
2. Spencer-Westlawn Elem 3071 Ralston Rd. Mobile 251-221-1705
3. Murphy High 100 South Carlen St. Mobile (251) 221-3186
4. Craighead Elem 1000 S. Ann St. Mobile (251) 221-1155

Health Hero Team 6________

1. Meadowlake Elem 8251 Three Notch Rd. Mobile (251) 221-1529
2. Haskew Elementary 7001 White Oak Dr. Irvington (251) 221-1850
3. St Elmo Elementary 8666 McDonald Rd. Irvington (251) 957-6314

Health Hero Team 7________

1. Regional School for the Deaf & Blind 3980 Burma Rd. Mobile (251) 221-5454
2. Shepard Elementary 3980-B Burma Rd. Mobile (251) 221-1645
3. Causey Middle 2205 McFarland Rd. Mobile (251) 221-2060
4. Hutchens Elementary 10005 West Lake Rd. Mobile (251) 221-1420
5. Dawes 3-5 10451 West Lake Rd. Mobile (251) 221-1485

Health Hero Team 8________

1. Council Traditional Elem 751 Wilkinson St Mobile (251) 221-1139
2. Leinkauf Elementary 1410 Monroe St. Mobile (251) 221-1495
3. Dunbar Magnet 500 St. Anthony St. Mobile (251) 221-2160

Health Hero Team 9________

1. Denton Magnet 3800 Pleasant Valley Rd. Mobile (251) 221-2148
2. Davidson High 3900 Pleasant Valley Rd. Mobile (251) 221-3084
3. Morningside Elem 2700 South Greenbrier Dr. Mobile (251) 221-1540
4. Pillans Middle 2051 Military Rd. Mobile (251) 221-2300
5. Gilliard Elementary 2757 Dauphin Island Mobile (251) 221-1820
6. Rain High 3125 Dauphin Island Mobile (251) 221-3233

Our teams arrive at the 1st school by 7:45 to set up for clinics. Please bring students a grade at a time to the designated location in order to maintain the 90 minutes per school schedule. It is important to the schools following your clinic that we stay on schedule. For students in Kindergarten or 1st Grade - please send with their school ID or label to help us confirm names and dates of birth. Please call us at 205-609-0268 with any questions or concerns.

HEALTH HERO
You Keep Them Smart
We Keep Them Healthy

FLU VACCINE CONSENT FORM

Scan QR code for Vaccine Information Statement

School Name: ____________________

PLEASE COMPLETE ALL OF THE INFORMATION BELOW – Please print using ink (Incomplete forms will not be accepted)									
FIRST NAME OF STUDENT		MIDDLE INITIAL		LAST NAME OF STUDENT				SUFFIX	
GENDER: Male (M) Female (F)		Birth date (mo/day/yr)		AGE		GRADE		HOMEROOM TEACHER	
ADDRESS								MOTHER'S MAIDEN NAME	
CITY		STATE		ZIP CODE		PHONE			
EMAIL									

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

MY CHILD IS ENROLLED WITH MEDICAID (VFC ELIGIBLE) (mark with an X)		MY CHILD HAS COMMERCIAL INSURANCE (NOT VFC ELIGIBLE) (mark with an X)		MEMBER ID POLICY NUMBER	
Alabama Medicaid	☐	BCBS / All kids	☐	INSURANCE COMPANY NAME	
		Aetna	☐	POLICY HOLDER's FIRST NAME	
		CHAMPVA	☐	POLICY HOLDER's LAST NAME	
		Cigna	☐	BIRTH DATE (mo/day/yr)	
		Tricare	☐		
		UMR- Wausau	☐		
		United Health Care	☐		
		Viva Health Plan	☐	MY CHILD HAS NO INSURANCE (VFC ELIGIBLE) (mark with an X)	☐

STOP
Do NOT return this form unless you want your child to be vaccinated.

STUDENT RACE (mark with an X)	
African American/Black	☐
White	☐
Asian	☐
Hawaiian / Pacific Islander	☐
Alaskan / Native- American	☐
Other	☐

ETHNICITY (mark with an X)	
Hispanic	☐
Non-Hispanic	☐

HEALTH QUESTIONS (mark with an X)	YES	NO
Will this be the first time your child has received a flu vaccine?	☐	☐
Has your child ever had an adverse reaction to any vaccine in the past including Guillain Barre syndrome?	☐	☐
Does your child have a blood disorder such as hemophilia or sickle cell?	☐	☐

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, HNH Immunizations Inc., MaxVax LLC., Health Heroes and it's affiliates, subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. I acknowledge that I am giving permission for HNH Immunizations Inc. to adjudicate and appeal claims with my insurance providers on my behalf. Clinic dates can be obtained from the school. I understand that the health-related information on this form will be used for insurance billing purposes and your privacy will be protected. I approve the use of my phone number to receive health related information. I request and voluntarily consent for the vaccine to be given and recorded in state registry for the person listed above.

PARENT/GUARDIAN WITH AUTHORITY TO AUTHORIZE VACCINATIONS SIGNATURE					
FIRST NAME		LAST NAME		DATE OF SIGNATURE (mo/day/yr)	
SIGNERS DATE OF BIRTH (mo/day/yr)				RELATIONSHIP TO CHILD	

Area for Official Administration Use Only
VIS CDC IIV 08/06/2021
Lot # __________ Exp: __________
Date: ____________________
____________________ LPN/RN/MD

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD's PEDIATRICIAN OR CALL US AT 205-609-0268 TO SPEAK TO A REPRESENTATIVE, PLEASE SEE WWW.HEALTHHEROUSA.COM FOR MORE INFORMATION

HNH Immunizations Inc.
326 Prairie Street N.
Union Springs, AL 36089
AL@healthherousa.com
205-609-0268

Parent or Guardian of: ______________________________

Vaccine consent form must be returned by: ______________________

HEALTH HEROES

Dear Parent / Guardian,

Students entering the 6th grade will require an additional dose of TDAP (tetanus-diphtheria toxoid & acellular pertussis) vaccine. Students must have this vaccine in order to enter 6th grade. This law became effective 2010 and may be found in Rules of the State Board of Health, Chapter 420-6-1.03(a).

If you would like to participate in our School Located Vaccination Clinic – **complete in full and sign** the consent form on the back of this form. Be sure to check the vaccines desired on the top of the form, if not checked- we will provide all the ACIP recommended vaccines that your child is currently due for. There is no out of pocket charge to parents for this service. If your child has Medicaid, AllKids, or private insurance, HNH will bill the insurance company for the vaccine. If your child is uninsured, the vaccine will be given free of charge.

If your child is covered by **PEEHIP** – we cannot provide vaccinations for your child. We apologize for this inconvenience- please contact PEEHIP at 1-877-517-0020.

Please see www.immunize.org or www.cdc.gov for current Vaccine Information Statement or more information regarding each of the vaccines recommended by CDC Advisory Committee on Immunization Practices (ACIP).

The following ACIP recommended vaccinations are available at the upcoming school located clinic:

Checked below are vaccines that your child should receive:
(School Nurse- please use ***ImmPrint forecast*** *to indicate non compliant vaccinations. A copy of the forecast must accompany the student consent form at the time of vaccination)*

- Tdap- Tetanus, diphtheria, pertussis : Boostrix® Ages 10 and older
- HPV- Human Papillomavirus: Gardasil® Ages 9-26 with a second dose after 6 months
- MCV- Meningococcal ACWY: Menveo® Ages 2 and up (with a booster dose recommended at age 16)
- MCVB – Meningococcal B: Bexsero® Ages 16-25 with a second dose after 30 days

Please return the consent form – completed – with the desired vaccines checked – only if you wish for your child to be vaccinated during the school clinic- if not, please discard this form and make an appointment with your child's healthcare provider, local health department or pharmacy.

Feel free to contact us at 205-609-0268 with any questions or concerns,

HNH Immunizations Inc.

WWW.HEALTHHEROUSA.COM

Vaccine Consent Form: School____________

Please select the vaccine(s) you consent for your child to receive:

Tdap ☐ MCV ☐ MCV-B ☐ HPV ☐ (Cancer preventative)

PLEASE COMPLETE ALL OF THE INFORMATION BELOW **Please print using ink** (Incomplete forms will not be accepted)

FIRST NAME of Student:	**LAST NAME of Student:**
Gender: Male Female — **Birthdate:** (month, day, year)	**Age** — **Homeroom Teacher / Grade**
Address	**Phone # ( )**
City — **Zip Code** — **State**	**Student Race:** (Circle one) African American / Black White Alaskan/ Native American Asian Hispanic Non-Hispanic Hawaiian / Pacific Islander Other :
Email address:	

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

Please fill out the following questions pertaining to your child's Health Insurance:

Insurance ☐ **Medicaid** ☐ **My child does NOT have health Insurance** ☐	**Insurance Company:**
Policy Holder's First Name:	**Policy Holder's Last Name:**
Member ID:or SSN	**Policy Holder's Date of Birth: (month/day/year)**

CHECK YES OR NO FOR **EACH** QUESTION

YES	NO	
☐	☐	1. Has your child ever had a life threatening reaction(s) with any vaccines?
☐	☐	2. Does your child have any allergies to latex?
☐	☐	3. Has your child ever had a condition called Guillain Barré Syndrome (GBS)?
☐	☐	4. Has your child ever had seizures or another nervous system problem?
☐	☐	5. If applicable, is the student pregnant or nursing?

STOP

Please do **NOT** return this form unless you want your child to be vaccinated.

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL US AT 205-609-0268 TO SPEAK TO A REPRESENTATIVE.

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, HNH Immunizations, Inc. & subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes .I give permission to HNH Immunizations Inc to discuss or appeal any claims with my insurance carrier on my behalf.

____________________ ____________ ____________________ ____________

Printed Name of Parent/Guardian | Relationship | Signature of Parent/Guardian | Date