Dear Parent or Guardian,

The Department of Health offers seasonal influenza vaccine to children ages 6 months through 18 years of age. Influenza vaccination helps protect children from the flu and its complications as well as decreases the spread of influenza within the community.

A school-based influenza vaccination clinic will be held at Corsica-Stickney School on 10/16/2025. This vaccination clinic is open to school aged children.

- The SD Department of Health will bill insurance directly for children covered by Medicaid or private insurance. If your child has insurance coverage, a copy of the Medicaid or insurance card must be attached to the paper Influenza Consent Form and returned to the school.

  SD DOH is considered in-network for the following insurance companies: *Avera, Sanford, Tricare, BCBS (not federal) and South Dakota Medicaid.* If you have questions about whether your insurance will pay for your child to receive a flu shot at this school-based clinic, please call our office to discuss or call your insurance company directly.

- If you choose not to bill insurance and/or do not provide a copy of your insurance card, the cost for vaccination is $50. Please send cash or check with your child (make checks payable to SD DOH).

- Children with limited or no health insurance qualify for vaccinations through a federal vaccine program that offers vaccinations at a reduced cost. Please contact the community health office to discuss this option if you believe your child may qualify.

- Children WILL NOT be vaccinated if we do not have a copy of an insurance card or have not received payment on the date of the scheduled flu clinic.

Please complete the following and return to the school:

1. Review the *Vaccine Information Statement* carefully. Keep for future reference.
2. Complete the ***Influenza Consent Form*** including a signature and phone number where you can be reached during the time of the clinic.
3. Attach a copy of your child's insurance or Medicaid card to the consent form.
4. Return the completed consent form to the school by **10/14/2025**

Please contact the Auora County Public Health Office at 605-910-4571 with any questions.

VACCINE INFORMATION STATEMENT

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 women, 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. Women 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. 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.

2025-2026 INACTIVATED INFLUENZA CONSENT FORM

Information about person to be vaccinated (please print)

Last Name:_____ Age:___ Sex: ___M ___F

First Name:_____ Date of Birth:_____

Race:_____ Language:_____

Ethnicity:_____Hispanic or Latino _____Non Hispanic or Latino

Mailing Address:_____ Zip:_____

City:_____ Phone #:_____

For child - Please Print

Parent's Name:_____

For child being vaccinated at school based clinic

Grade _____ School _____

For clinic use only

Assessment of Vaccination history for child under age 9

_____ Child will need 2nd dose

_____Additional information needed

Clinic : Aurora County Public Health

Entered into EHR: Date_____ Initials _____

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information in accordance with applicable HIPAA Privacy Act standards and requirements. Immunization records remain confidential, and any person who fails to protect the information is guilty of a Class 1 misdemeanor. If you choose not to have the record of this immunization shared with other providers, you may request a refusal form.

INSURANCE Status

___ Insurance **(MUST ATTACH COPY OF CARD)**
___ Medicaid * **(MUST ATTACH COPY OF CARD)**
___ No Insurance *
___ Insurance that DOES NOT cover vaccines *
___ American Indian or Alaskan Native 18 yrs. and under *

For Dependent Covered by Private Insurance

Name of Policy Holder _____

Policy Holder Date of Birth _____

Relationship _____

* *Children age 18 and under in these categories are Vaccines for Children Program eligible*

Please answer the following for the person to be vaccinated.

	Yes	No	Don't Know
1) Is the person sick today?	____	____	____
2) Does the person have an allergy to an ingredient of the vaccine?	____	____	____
3) Has the person ever had a serious reaction to influenza vaccine in the past?	____	____	____
4) Has the person ever had Guillain-Barré syndrome?	____	____	____
5) Has the person ever felt dizzy or faint before, during or after a shot?	____	____	____
6) Is the person anxious about getting a shot today?	____	____	____

I have been provided a copy of and have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

If insured, I authorize SDDOH to release medical information necessary to determine benefits payable for this service. I understand that I am financially responsible for services regardless of insurance coverage.

Signature _____ **Date** _____

Person to be vaccinated (If minor, parent or guardian)

For child being vaccinated at a school based clinic

If completing this form for a child to be vaccinated at school and you will not be accompanying him/her, please provide a phone number where you can be reached on the day of the clinic. (Phone) _____

for office use only

	Type	Date/Time	Vaccine Manufacturer (Circle)	Vaccine Lot number	Dose	IM Site (Circle)	Date of VIS Publication	Full Signature of person administering vaccine
INFLUENZA	IIV 3	10/16/2025	GlaxoSmithKline	4D255 7345R	0.5 mL	L R Deltoid Thigh	1/31/2025	

Abbreviation Key: **IIV3** - Inactivated Influenza Vaccine, Trivalent **IM** - Intramuscular **L** - Left **R** - Right