October 8, 2024

Dear Parent or Guardian,

The community health office will be coming to the Corsica Stickney School – Corsica Campus on Thursday, October 17th, 2024 to offer flu shots. The influenza vaccination helps protect children from the flu and its complications. It also helps decrease the spread of influenza in the community.

Thursday, October 17th, 2024
8 a.m.
Corsica Campus – in the library

What we need the day of the school flu clinic:

- **Consent formed filled out – <u>for each student</u>**
- **Financial responsibility form signed**
- **Copy of insurance card – front & back**

If we do not have your child's insurance information, we will not be able to give the flu shot that day.

If your child is not covered by Medicaid or private insurance, they qualify for vaccination through a federal vaccine program.

If you are unsure if your insurance covers the flu vaccine, please call your insurance company.

If you have any questions please contact Cassandra.
Douglas County Community Health Office
724.2758

2024-2025 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 :

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		GlaxoSmithKline		0.5 mL	L R Deltoid Thigh	8-06-2021	

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

S.D. Department of Health Notice of Privacy Practices can be viewed at https://doh.sd.gov/documents/HIPAANotice.pdf Rev. 06/2024

;FOR ALL FACILITY USE: NAME:_____

E#_____ DOB:_____

Douglas County Memorial Hospital

Statement of Financial Responsibility and Assignment of Benefits

Financial Responsibility

I agree that I am financially responsible for all charges related to services provided by Douglas County Memorial Hospital and/or Prairie Health Clinic. I also agree to abide by DCMH/PHC's payment guidelines. All patient accounts will be considered due upon receipt of the billing statement. As a courtesy, the business office will process my insurance if proper information is provided. It is understood that all insurance deductibles be paid at the time of dismissal. I will be billed on the current balance of my account regardless of the insurance claim status. Accounts over 60 days may be referred to a collection agency and may be charged up to 1% interest per month. If I have additional questions about my financial responsibility for DCMH/PHC charges I may contact the business office.

Further, if I am provided health care services by a health care provider other than DCMH/PHC while a patient within this facility or entity, I am financially responsible for all charges related to services provided by my health care provider. Billing statements will not include charges by health care providers who are independent of DCMH/PHC. I agree to abide by my health care provider's payment guidelines.

Additionally, I agree DCMH/PHC, or its third party vendor, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers. Methods of contact may include text messaging, email, using a pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Assignment of Payer Benefits

I understand DCMH/PHC and my attending health care provider will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private and government health plan or insurance policy that I have or another third party that will pay the charges I have incurred. All Payers may make payments directly to DCMH/PHC and my attending health care provider. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to DCMH/PHC and my attending health care provider. I agree that unless DCMH/PHC or my attending health care provider have agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services.

Medicare Beneficiary Request for Payment and Assignment of Benefits

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to DCMH/PHC and my attending health care provider for any services furnished to me by DCMH/PHC and my attending health care provider, including physician services. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents, any information needed to determine these benefits or the benefits for related services.

Responsibility for Personal Valuables

I understand that I am responsible for my personal valuables (including money, jewelry, dentures, hearing aids, eyeglasses, etc.) while a patient here unless I ask to lock my personal items in a secure location. I hereby release this facility or any hospital employee from any liability from loss, by theft or negligence of mine.

Acknowledgment

I have read the information above and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified above, I agree that a representative for me is authorized by law to agree to these conditions on my behalf. A copy of this form is as effective and valid as the original.

_____ _____

Signature of Patient or Authorized Person Date

_____ _____

Relationship to Patient (if not patient signing) Reason Patient not signing

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 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.