

September/October 2021

Parent(s)/Guardian(s):

The Springfield School District, in cooperation with CoxHealth, with support from Springfield Greene County Health Department and Mercy is offering Seasonal Flu Vaccine to any child free of charge, as supply allows. Your child will receive the Inactivated Influenza (Flu Shot) Vaccine.

The Flu Clinic will be held at Hillcrest on October 1, 2021.

The following conditions would prevent your child from receiving flu vaccine: allergy to vaccine components, and moderate or severe illnesses. The Vaccine Information Statement for the Inactivated Influenza Vaccine (Flu Shot) is included with this letter. Parents are encouraged to review the information and for those with children who have significant health risks to arrange their immunizations with their primary care provider.

If you are interested in your child receiving the Inactivated Influenza Vaccine (Flu Shot), please complete and sign the consent form and return it to your child's school nurse before the school flu clinic.

The clinics will be held as supply allows. If you have additional questions about the program, please call the Hillcrest health office at 417-523-8025.

School Hillcrest

FLU IMMUNIZATION CONSENT FORM

Grade _____

Teacher _____

Student ID# _____

The Springfield School District, in cooperation with CoxHealth, is offering seasonal flu vaccine to any child who qualifies for the Vaccines for Children (VFC) Program, as supply allows. If you would like your child to receive the flu vaccine, please complete this form. All vaccines given at these clinics are provided free of charge.

The Inactivated Influenza (FLU Shot) will be administered.

- 1) **QUALIFYING CHILDREN for VFC:** Check which applies for your child (at least one must apply):
- | | |
|--|---|
| <input type="checkbox"/> he/she has no insurance | <input type="checkbox"/> he/she has insurance, but it does not cover vaccinations |
| <input type="checkbox"/> he/she has Medicaid | <input type="checkbox"/> he/she is an Alaskan native or Native American |

In addition, for those students with private insurance coverage that fully covers vaccinations and therefore not qualifying for VFC, inactivated influenza vaccine (FLU shot) has been provided by CoxHealth, Springfield Greene County Health Department, and Mercy-Springfield and will be given free of charge. Please check if your child has private insurance that pays fully for vaccinations (Not Medicaid)

he/she HAS private insurance (not Medicaid) that pays fully for vaccinations.

Please review the Vaccine Information Sheet provided for inactivated influenza vaccine. If you have questions about the vaccine that are not answered on the Vaccine Information Sheet, please talk to your school nurse.

2) CHILD'S INFORMATION:

Child's Name: _____ SS# _____ Gender: M F Race _____
 Child's Date of Birth: _____ Medicaid No: _____ Language: _____
 Child's Mother/Father/Guardian Name: _____ Date of Birth: _____ Phone: _____
 Child's Street Address: _____ City _____ Zip: _____

3) PLEASE CIRCLE 'YES' OR 'NO'

- | | | |
|--|-----|----|
| 1. Has your child received a vaccine within the past 30 days?
If yes, please list name of vaccine(s): _____ | Yes | No |
| 2. Has your child received a flu vaccination before? | Yes | No |
| 3. Is your child allergic to any part of the vaccine (eggs, egg proteins, gentamicin, gelatin, or arginine)? | Yes | No |
| 4. Has the child ever had a life-threatening reaction to an influenza vaccine? | Yes | No |
| 5. Is your child currently receiving aspirin or aspirin-containing therapy? | Yes | No |
| 6. Does your child have asthma, recurrent wheezing, or active wheezing? | Yes | No |
| 7. Has your child ever had Guillain-Barré syndrome? | Yes | No |
| 8. Does your child have any diseases (for example, cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids or chemotherapy) that lowers the body's resistance to infection? | Yes | No |
| 9. Does your child have any of the following long-term health problems? (CHECK CIRCLE)
<input type="checkbox"/> heart disease <input type="checkbox"/> kidney disease <input type="checkbox"/> metabolic diseases (for example, diabetes)
<input type="checkbox"/> other _____ | | |
| 10. Is your child pregnant or nursing? | Yes | No |
| 11. Please let us know if your child has close contact with anyone who has a weakened immune system (for example, an individual who has had a bone marrow transplant and is in a negative pressure hospital room). Please describe: _____ | | |

Allergies/medical alert: _____

4) READ AND SIGN BELOW:

Request for administration of inactivated Influenza (FLU Shot): I have been given the CDC Vaccine Information Statement. I have read this document and have no further questions at this time. I understand that my child will receive the inactivated Influenza (FLU shot) vaccine. I understand the risks and benefits of the inactivated intramuscular influenza vaccines. I request and voluntarily consent that the vaccine be given to the above-named recipient, of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccine.

Signature of Parent/Guardian _____ Date _____