Dear Parent/Guardian:

CCSD Nursing Services will be working with Title I schools to provide FREE flu vaccines at your child's school this fall. The flu vaccine will be available in 2 forms:

- **Flu shot**
  Or
- **Flu nasal spray.**

A flu vaccine is recommended by CDC and DHEC every year for everyone 6 months of age and older. It is the best way to protect your child against the flu. Please note that experts are predicting a worse than normal flu season. We urge you to consider signing your child up to receive the FREE flu vaccine at school.

Here are a few things to keep in mind:

- Children in close settings like schools are at higher risk of getting sick with the flu and may spread it to other students and teachers as well as those in their household and community.
- If your child has asthma, diabetes or other chronic health conditions, they are more likely than other children to become very sick if they get the flu. It is especially important for children with any of these conditions to get the flu shot every year.
- Your child can get the flu shot or flu nasal spray at school from a CCSD nurse and you do not need to miss work to take them to the doctor's office.
- The flu is a primary reason that students (and parents) miss school days during influenza season.

Please complete and return the consent form as soon as possible.
Information about the date and time of the flu clinic will also be provided by your child's school.

Don't forget to get yourself and your family vaccinated against the flu! Flu vaccine is available from your local DHEC health department and your health care provider. Those 12 years of age and older can receive the flu vaccine at a pharmacy which offers flu vaccine. We encourage you to choose the one that works best for you.

More information about the flu and flu vaccine clinics is available on the DHEC website at www.scdhec.gov/flu.

Thanks for doing all you can to stay healthy and well!
CCSD Nursing Services

[redacted]

FLU VACCINE
PARENT CONSENT FORM

[redacted]

STUDENT INFORMATION (USE BLACK INK ONLY)

STUDENT FIRST NAME	MI	STUDENT LAST NAME	AGE	GRADE

DATE OF BIRTH (MM/DD/YYYY)	GENDER ☐ Male ☐Female	SCHOOL	HOMEROOM TEACHER

STREET ADDRESS	CITY	STATE	ZIP

PARENT/GUARDIAN FIRST NAME	PARENT/GUARDIAN LAST NAME	PARENT/GUARDIAN CELL PHONE
		( ) -

INSURANCE INFORMATION (PLEASE FILL OUT COMPLETELY)

MEDICAID	☐ Yes (Enter Medicaid Number) ☐ No (Continue completing form)	SC MEDICAID NUMBER
INSURANCE	☐ Yes (Enter insurance information) ☐ No (Skip to screening questions)	VACCINE COVERED ☐ Yes ☐ No

Check the vaccine you would like your child to receive: ☐ FluMist (Nasal Spray) ☐ Flu (Injection)

VACCINE SCREENING QUESTIONS

PLEASE ANSWER ALL QUESTIONS BELOW:

1. Has your child ever had a serious reaction to eggs **OR** a serious reaction to a previous flu vaccine that caused any of the following: wheezing, trouble breathing, hives and itching all over the body, swelling in the moth or throat, very low blood pressure or shock?	☐ Yes ☐ No
2. Has your child ever had Guillain-Barre Syndrome (a rare type of temporary severe muscle weakness and paralysis)?	☐ Yes ☐ No
If you answered YES to either question 1 or 2, your child cannot receive the 2022-2023 seasonal influenza vaccine at school. Please see you child's primary healthcare provider.	
3. Has your child received Varicella (chicken pox), Measles, Mumps and/or Rubella within the past 30 days? If so please list	☐ Yes ☐ No
4. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidney, liver, nerves, or blood (including anemia); or have a cochlear implant or spinal fluid leak, or no spleen?	☐ Yes ☐ No
5. Does your child take aspirin or a medication that contains aspirin every day?	☐ Yes ☐ No
6. Does your child have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	☐ Yes ☐ No
7. Is your child pregnant?	☐ Yes ☐ No
8. Is your child currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than 2 weeks?	☐ Yes ☐ No
9. Does you child have close contact with a person who needs car in a protected environment (bone marrow transplant)?	☐ Yes ☐ No
10. Did you child recently receive any of the following antivirals below: • Oseltamivir or Zanamivir in the last 48 hours • Peramivir in the last 5 days • Baloxavir in the last 17 days	☐ Yes ☐ No
If you answered YES to any questions 3-10, your child cannot receive the nasal spray flu vaccine. He/she will receive the flu shot. **If you answered NO to questions 3-10, please select the preferred vaccine for your child:** ☐ **FluMist (Nasal Spray Live Attenuated Influenza Vaccine LAIV)** ☐ **Flu Shot (Inactivated Influenza Vaccine quadrivalent IIV4)**	
If your child is under 9 years old: Has your child received at least two doses of influenza vaccine prior to July 1, 2022? If no or unsure, he/she may need 2 doses of flu vaccine this year.	☐Yes ☐ No ☐ Maybe

AUTHORIZATION, CONSENT AND RELEASE

I voluntarily request and consent for the Charleston County School District (CCSD) to provide the above selected vaccines for my child named on this form. I also, consent for my child to receive these vaccines at school, to be administered by CCSD nursing staff. I have been provided the Vaccine Information Statements. These can also be found at www.cdc.gov/vaccines/hcp/vis/current-vis.html. I have had an opportunity to ask questions about the vaccines. I understand the risks and benefits of the vaccines. I understand that the vaccines will be given as a shot. I have read and answered the questions above carefully and accurately, and I understand that incorrect information could cause serious risks to my child. In case of occupational exposure, I consent to my child's blood testing if necessary for child and employee safety. I understand that immunization information about my child will be reported to SC Immunization Registry for public health purposes. I hereby RELEASE AND HOLD HARMLESS CCSD, its employees, trustees, and/or agents ("Releasees") from any and all liability, claims, demands and causes of action of whatever kind or nature, either in law or equity, which may arise as a result of receiving the requested vaccines, including claims of bodily and/or mental injury, illness, or death, whether caused by the negligence of Releasees or otherwise.

I further consent to CCSD releasing and exchanging information about the service provided along with my child's name, date of birth, Medicaid or health insurance number, gender, as well as and my contact information to the Medicaid Agency (Department of Health and Human Services); and for CCSD to bill and receive payment for the services described herein from the Medicaid Agency. I understand that Medicaid reimbursement for Non-IEP nursing services provided by CCSD will not affect any other Medicaid services for which my child is eligible. CCSD will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) to ensure confidentiality regarding my child's treatment and provision of Non-IEP nursing services.

I have read the above Consent, Authorization and Release and understand its provisions and applicability and have been given the option and recommendation of consulting with my own personal physician. I understand that participating in the vaccination program is totally voluntary and that my child is not required to participate. I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

SIGNATURE OF PARENT ORLEGAL GUARDIAN

DATE

Charleston County SCHOOL DISTRICT

VACCINE ADMINISTRATION DOCUMENTATION
(CLINIC USE ONLY)

VACCINE HISTORY		
Documentation	**Nurse's Initials**	**Comments**
No Contraindications or Precautions		
No Allergies		
Previous Doses (if applicable)		
Not pregnant (if female)		

VACCINE ELIGIBILITY			
Eligibility Code	**Eligibility Category**	**Eligibility Check**	**Comments**
1	Pediatric VFC> Medicaid		
2	Pediatric VFC>AA/AN		
3	Pediatric VFC> No Health Insurance		
4	Pediatric State > Underinsured/Hardship		
5			

Dose 1 DOCUMENTATION								
Vaccine Name	**Dosage**	**Dose #**	**Site**	**Route**	**Manufacturer**	**Lot #**	**VIS**	**Elig**
Influenza (IIV4)	0.5 ml			IM	GSK		08/06/2021	
Influenza (LAIV4)	0.5 ml			Nasal	MI		08/06/2021	

Dose 2 DOCUMENTATION								
Vaccine Name	**Dosage**	**Dose #**	**Site**	**Route**	**Manufacturer**	**Lot #**	**VIS**	**Elig**
Influenza (IIV4)	0.5 ml			IM	GSK		08/06/2021	
Influenza (LAIV4)	0.5 ml			Nasal	MI		08/06/2021	

SIGNATURE/TITLE PERSON ADMINISTERING VACCINE	DATE
CLINIC SITE	IIS ENTRY COMPLETE ☐

SCHOOL DISTRICT