

***Spencer Community Schools
23 East 7th Street, Box 200
Spencer, IA 51301***

August 3, 2011

Dear Parents:

Our school, in cooperation with Clay County Public Health and Avera Medical Group-Spencer will be offering the **FluMist influenza vaccine** to students this fall. Please read the following information carefully. If you would like your child to receive this vaccine, the consent form (on the back of this letter) needs to be completed, signed and returned to the school office no later than **September 15**.

WHAT: FluMist (nasal-spray flu vaccine) Vaccination at School. This vaccine will help prevent seasonal flu.

WHY: FluMist is needle-free! School-age children are up to four times more likely to be infected with influenza than adults.

WHEN: FluMist will be given during a school day this fall, likely in October. A date will be confirmed once vaccine supply is available. Please watch the school website for updates.

HOW: Nurses from Clay County Public Health and Avera Medical Group-Spencer will administer the vaccines. If your child does not qualify for FluMist, based on the screening questions, he/she may get a flu shot from your healthcare provider.

COST: FluMist is not necessarily free but will be given at little or no cost depending on healthcare coverage.

Please read the following carefully...

- **If your child is covered by a private health insurance plan (*not Medicaid, Title-19*), it is your responsibility to check with your insurance company ahead of time to see if FluMist is covered. If so, please be sure Avera Medical Group-Spencer has your most current insurance information as a claim will be filed with your insurance company. You will be responsible for any unpaid portion.**
- **If your child does not have coverage for FluMist, or is covered by Medicaid, or has no health insurance, the Vaccines for Children (VFC) Program will cover the cost of the vaccinations. Other eligibility guidelines are listed on the consent form.**

Some children under age 9 may need 2 doses, if they have not received flu vaccine in the past. You will be notified if this dose is needed.

Consider taking advantage of this convenient method to get your child protected from the flu! We request that you read the accompanying materials closely to understand any risks and the benefits of this vaccine and return the consent form to your child's school by **September 15**.

If you have any questions, please call Colette Rossiter with Clay County Public Health at 264-6468 or crossiter@spencerhospital.org

FLUMIST VACCINATION CONSENT FORM-SPENCER SCHOOLS

IMPORTANT! IF YOU ANSWER **YES** TO ANY QUESTION, YOUR CHILD **CAN NOT** RECEIVE FLUMIST AT THE SCHOOL CLINIC.

CHILD'S PERSONAL INFORMATION: (PLEASE PRINT)

YOUR CHILD'S SCHOOL BUILDING _____

LAST _____ FIRST _____ M.I. _____ GENDER _____

BIRTHDAY _____ AGE _____ EMAIL ADDRESS: _____

ADDRESS _____ CITY _____ ZIP CODE _____

HOME PHONE # _____ ALTERNATE PHONE # _____

PARENT / GUARDIAN _____ PHYSICIAN _____

- Y OR N HAS YOUR CHILD ALREADY RECEIVED A FLU SHOT THIS FALL (2011)?
- Y OR N DOES YOUR STUDENT HAVE AN ALLERGY TO EGGS OR TO FLU VACCINE?
- Y OR N HAS YOUR STUDENT HAD A SERIOUS REACTION TO FLUMIST IN THE PAST?
- Y OR N DOES YOUR STUDENT HAVE A LONG-TERM HEALTH PROBLEM (ASTHMA, HEART DISEASE, DIABETES, ANEMIA, OR OTHER BLOOD DISORDER)?
- Y OR N HAS YOUR STUDENT HAD ONE OR MORE EPISODES OF **WHEEZING** WITHIN THE PAST YEAR?
- Y OR N DOES YOUR STUDENT HAVE A WEAKENED IMMUNE SYSTEM BECAUSE OF DISEASE OR LONG TERM TREATMENT WITH DRUGS SUCH AS STEROIDS OR CANCER TREATMENTS?
- Y OR N DOES YOUR STUDENT RECEIVE DAILY ASPIRIN THERAPY?
- Y OR N IS YOUR DAUGHTER PREGNANT OR COULD SHE BECOME PREGNANT IN THE NEXT MONTH?
- Y OR N HAS YOUR CHILD EVER HAD GUILLAIN-BARRE SYNDROME (GBS)?
(IF YOU DON'T KNOW WHAT THIS IS, YOUR STUDENT HAS NOT HAD IT)

IMPORTANT!

YOU MUST CHECK ONE OF THE FOLLOWING REGARDING YOUR CHILD'S HEALTHCARE COVERAGE:

VFC ELIGIBLE (NO CHARGE FOR VACCINE)

_____ **IS ENROLLED IN MEDICAID (TITLE XIX). MEDICAID NUMBER:** _____

_____ **DOES NOT HAVE HEALTH INSURANCE.**

_____ **IS AN AMERICAN INDIAN OR ALASKAN NATIVE.**

_____ **HAS HEALTH INSURANCE THAT DOES NOT PAY FOR VACCINES.**

NOT VFC ELIGIBLE (INSURANCE CLAIM WILL BE FILED)

_____ **INFLUENZA VACCINES AND ADMINISTRATION ARE COVERED BENEFITS OF OUR INSURANCE PLAN**

I HAVE BEEN GIVEN A COPY AND HAVE READ, OR HAVE HAD EXPLAINED TO ME, THE INFORMATION CONTAINED IN THE VACCINE INFORMATION STATEMENT. I HAVE HAD A CHANCE TO ASK QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THE FLUMIST VACCINE AND REQUEST THAT THE VACCINE BE GIVEN TO MY CHILD. IT IS MY RESPONSIBILITY TO INFORM THE SCHOOL ABOUT ANY CHANGE IN THE STATUS OF THE ABOVE SCREENING QUESTIONS PRIOR TO VACCINATION WITH IN THE NEXT 2 MONTHS.

SIGNATURE OF PARENT / GUARDIAN _____ **DATE** _____

FOR CLINIC USE ONLY				
	Date Given	Site / Route	Manufacturer / Lot # / Exp.date	Administered By
FluMist LAIV		Intranasal	Medimmune /	
VIS Date: 7/26/11				