Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562
(614) 525-3160
www.myfcph.org

School Flu Consent /Administration Form
Immunization Program

Office Use Only	Date: ☐ in NextGen
	Location:

Person receiving vaccination

First Name:	MI:	Last Name:		
Address:	City:		State:	Zip:
Phone:	Date of Birth:	Age:	Gender: ☐ Male ☐ Female	

Race (check all that apply): ☐ Asian ☐ Black/African American ☐ White ☐ Native American or Alaskan Native ☐ Other_____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Parent/ Legal Guardian (if applicable)

First Name:	Last Name:
Relationship to Child:	Phone:

Insurance Information

Please mark insurance status and provide appropriate information (select all that apply):

☐ **Medicaid Insurance that Franklin County Public Health is ABLE TO Bill:**

- ☐ Buckeye
- ☐ CareSource
- ☐ Molina
- ☐ Ohio Medicaid
- ☐ Paramount
- ☐ UnitedHealthcare (UHC) Community

☐ **Private Insurance that Franklin County Public Health is ABLE TO BILL:**

- ☐ Aetna (**except** Open Access Managed Choice)
- ☐ Aetna – Meritain Health
- ☐ All Savers through UHC
- ☐ Anthem BC/BS
- ☐ CareSource Marketplace/Healthcare Exchange plans
- ☐ Cigna
- ☐ Golden Rule through UHC
- ☐ Medical Mutual (**except** OhioHealth HMO)
- ☐ UMR through UHC
- ☐ UnitedHealthcare (UHC) (**except** OSU; OSU Student Resources; Compass)

☐ **Other Insurance not listed above: Your child will NOT be vaccinated by FCPH. Please check with your Insurance for a list of Providers who are within your network to receive vaccines.**

☐ **No Insurance** (Your child will receive Vaccines For Children federally funded vaccine for no charge)

Financial Responsibility Statement- Initial if we are billing your insurance

I agree to promptly pay with settlement in full for the medical services provided to myself and/or minor child at the prevailing rates as bill are presented. I understand that I am financially responsible for all the charges that are not covered by my insurance plan. I authorize FCPH to submit a claim to my insurance carrier and I authorize payment directly to FCPH.

** **Initial here →** ☐

Rev 08/28/19

You must complete the backside of this form TURN OVER→

Person being vaccinated Name:_____ **Date of Birth:**_____

Screening questions for person receiving vaccine

1. Have any allergies? Especially to latex, gelatin, chicken eggs/feathers? ***If YES, please list allergies**_____	☐ **Yes** ☐ **No**
2. Any serious reactions after receiving vaccines in the past? ***If YES, please describe**_____	☐ **Yes** ☐ **No**
4. Ever had Guillain-Barré syndrome?	☐ **Yes** ☐ **No**

Consent for Treatment

To the best of my knowledge, I understand the benefits and/or risks of vaccines. I hereby give consent to Franklin County Public Health (FCPH) staff for the administration of the vaccine to myself or for the individual for whom I am authorized to make said request. I have received a copy of the most up-to-date Vaccine Information Statement (VIS). I understand that I will have the chance to ask questions and have them answered to my satisfaction. I acknowledge that I have been offered and/or received the FCPH Notice of Privacy Practice Summary (HIPAA), which explains policies concerning my personal health information. FCPH is authorized to release vaccination information to schools, day cares, and/or others as necessary or required for treatment of care and billing purposes.

Signature (Parent/Legal Guardian's if <18 y.o.): **Date:**

For Staff Use Only

Medical Screener Signature:_____ **VFC** **Private**

Is the child sick today? ☐ **No** ☐ **Yes** **If yes, describe:**_____

☐ **6 months through 64 years Fluzone- prefilled syringe**

Age _____ ☐ 0.5 ml (90686) ☐ Lot #_____ ☐ IM ☐ Left Thigh ☐ Right Thigh ☐ Left Deltoid ☐ Right Deltoid

☐ **4 years through 64 years Flucelvax- Multi-dose vial**

Age _____ ☐ 0.5 ml (90756) ☐ Lot #_____ ☐ IM ☐ Left Thigh ☐ Right Thigh ☐ Left Deltoid ☐ Right Deltoid

Vaccinator Signature:_____ **Date:**_____

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 of age 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.

Each 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 vaccine

CDC recommends everyone 6 months of age 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 three or four viruses that are 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 vaccine 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 to a future visit.

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 shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- 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 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. 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. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's **www.cdc.gov/flu**

You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired, which must be less than a 6-year period and starting after April 14, 2003. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

If this notice was sent to you electronically, **you have the right to a paper copy of this notice.**

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

You may request, in writing, that we not use or disclose medical information about you for treatment, payment or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request **but we are not legally required to accept it.** We will inform you of our decision on your request. All written requests or appeals should be submitted to our Privacy Officer. These Privacy Practices have been in effect since April 14, 2003.

Complaints/Questions

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact the Health Commissioner's office at:

Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215

Phone: (614) 525-3670
Fax: (614) 525-6672
E-mail: fcph@franklincountyohio.gov

Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. You may call 1-866-627-7748 to obtain their address.

Under no circumstance will you be penalized or retaliated against for filing a complaint.

Privacy Information is available on the web at www.myfcph.org.

Consent Form Section:
Receipt of Notice of Privacy Practices

I have read and/or have had explained to me my rights and obligations concerning my health information. By signing below, I acknowledge receiving this Notice of Privacy Practices Summary.

Last Name: _____

First Name: _____ **M.I.** _____

Signature: _____

Date: _____/_____/_____

Franklin County
Public Health

Notice of Privacy Practices Summary

Revised April 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
If you have any questions, please see the Complaint/Question section on the back of this pamphlet for contact information.

Who will follow this notice?

Franklin County Public Health (FCPH) provides healthcare to our patients, residents, and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any healthcare professional who treats you at any FCPH-sponsored locations.
- All divisions of FCPH.
- All employed associates, staff or volunteers of FCPH.
- Any business associate or partner of the FCPH with whom we share health information.

Our pledge to you

We understand that medical information about you is personal, and we are committed to protecting it. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by FCPH staff or your personal doctor. We are required by law to:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

Changes to this notice

We may change our Privacy Policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our Privacy Policies, we will change our notice and post the new notice in a prominent place within of facility or clinic sites. You can receive a copy of the current notice or policy at any time. The effective date is listed just below the title. You will be offered a copy of the current notice when you first register at our facility or clinic sites for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose medical information about you

FCPH participates in the CliniSync Health Information Exchange in Ohio. Your doctors and healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs.

We and other healthcare professionals may allow access to your health information through the CliniSync Health Information Exchange for treatment, payment or other healthcare operations.

If you have questions or do not wish to have your records shared electronically, please contact FCPH (614) 525-3670.

We may use or disclose medical information about you **without** your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for **public health purposes** (community health surveillance, investigation, or tracking), **abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donation, workers' compensation purposes, and emergencies.** We also disclose medical information **when required by law**, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

We also may contact you for **appointment reminders**, or to tell you about or recommend **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you.

We may disclose medical information about you to a **friend or family member who is involved in your medical care**, or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of medical information

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you

In most cases, **you have the right to look at or get a copy of medical information** that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related expenses. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or if important information is missing, **you have the right to request that we correct the records** by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.