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Public Health Solutions

District Health Department

Serving Fillmore, Gage, Jefferson, Saline, and Thayer counties.

The SKIP Flu immunization clinic will be offered at your child's school on **Wednesday October 27, 2021.**

Public Health Solutions will offer flu immunizations within the school this October. We will also offer the Pfizer Covid-19 Vaccine for anyone aged 12 and over. This year we encourage everyone to "Sink the Flu and Covid-19 Too!".

It is more important than ever to remain as healthy as possible because there is also an increased health risk with the Covid virus. It is going to be very important for as many people to receive the flu and Covid-19 immunizations as possible this year. Increasing the amount of people who are immunized will help to reduce the spread of the flu and Covid-19. We realize that the flu shot does not guarantee to protect 100% against getting the flu, but it will greatly reduce the length and severity of symptoms should you get the flu and protect your family and friends. The Covid-19 Vaccine will help protect you from severe illness if you are exposed to Covid.

To have your child vaccinated, please do the following:

1. **Complete and Sign the Permission Form.**
   You must complete the attached Permission Form/Forms and answer **all** the Screening Questions. Return the completed form to your child's school. **Children without a *completed* and *signed* consent form will *not* be immunized. All questions must be answered.**

2. **Insured? - - Just include a copy of your insurance or Medicaid/Medicaid Managed Care Cards**
   Please *include a photocopy* of your insurance or Medicaid/Medicaid Managed Care card. There will be **no cost to your family** as we bill the insurance company. If you are requesting a Covid-19 Vaccination only, no insurance information is necessary.

3. **Are you uninsured?**
   Mark the uninsured box on the Permission Form. There will be **no charge** for the vaccination thanks to the support from the county boards and from federal vaccine funding.

4. **Show these Viruses who is the Winner!**
   Every student who turned in their Consent Form **and** got the flu shot the day of the clinic will be entered into a drawing for a $20.00 gift card.

Children under the age of nine who have never had the flu vaccine before, or did not receive two doses prior to this year, will need a second dose (booster). Our nurses will review your child's record and will let you know if a booster is needed.

If you need a flu shot, or know someone who needs one, and are unsure where to go, please call us! ***Remember—your flu shot protects both you and those you love!*** Questions? Call Public Health Solutions District Health Department at 402-826-3880 or toll-free 1-844-830-0813.

This program is supported by Public Health Solutions Board of Health and County Commissioner / Supervisor Boards which help provide funding for anyone who is uninsured.

Sincerely,

Kimberly Showalter
Health Director

Public Health Solutions Vaccine Screening / Permission Form
Inactivated Injectable Seasonal Influenza Vaccine 2021-2022

The information collected on this form will be used to make sure we have permission to give vaccine. The vaccination will be recorded on Nebraska's state immunization site.

Name: _____ Date of Birth: _____ Sex: Male Female

Address: _____ City/State/Zip: _____ Phone: _____

☐ Insurance **(COPY ATTACHED)** ☐ Medicaid/Managed Care **(COPIES ATTACHED)** ☐ Uninsured

School: _____ Doctor: _____

SCREENING QUESTIONS –***Parent/Guardian: Please answer all the questions below with either YES or NO. Vaccine will not be given if this form is not completed, signed and returned to school on or before flu vaccine day.***

1. Does the person getting flu vaccine feel sick or have a fever today?	Yes / No
2. Is this person allergic to eggs, latex, *thimerosal* or *gentamicin*?	Yes / No
3. Has this person ever had a severe allergic reaction to flu vaccine?	Yes / No
4. Has this person ever had *Guillain-Barré* syndrome within 6 weeks of receiving flu vaccine?	Yes / No

Definitions

Severe allergic reaction – (anaphylaxis) – a quickly developing, exaggerated response by the body to any substance. Symptoms are reddening of skin, itching, hives, runny or stuffy nose, swelling of the lips, tongue, and/or throat, trouble swallowing, trouble breathing, anxiety, fast irregular heartbeat, and cramping in the abdomen.

Thimerosal – a preservative found in some vaccines.

Gentamicin – An antibiotic medicine found in some vaccines.

Guillain - Barré Syndrome – A disease of the nerves. Symptoms are muscle weakness and decreased feeling beginning in the legs and moving upward, sometimes causing a person to be paralyzed or have trouble breathing.

Permission: Please read the statements below very carefully.

- I have been given a copy of the 2021-2022 Influenza Vaccine Information Statement (VIS), and I have read and/or have had explained to me the information on influenza (flu) disease and influenza (flu) vaccine.
- I've had the opportunity to ask questions and have those questions answered to my satisfaction.
- I understand the risks and benefits of vaccination against influenza (flu), and I request that the influenza (flu) vaccine be given to me or the person named above for whom I am authorized to make this request.
- I understand and agree that Public Health Solutions and my child's school are not responsible for any adverse reactions that may occur and that it is my responsibility to seek medical attention for my child or myself should an adverse reaction occur.

Signature: _____ Date: _____

Parent of child receiving vaccine or adult receiving vaccine

For Office Use Only

Nurse Signature: _____

Nurse: Please attach vaccine information sticker here and sign form.

Seasonal Flu 2021-2022

PUBLIC HEALTH SOLUTIONS COVID-19 VACCINE SCREEING FORM
PFIZER COVID 19 VACCINE

The following questions will help decide if there is any reason you should NOT receive COVID-19 vaccine today. Answering "yes" to any question does not mean you should not get vaccinated. It means you may be asked more questions. If you do not understand a question, ask you healthcare provider to explain it.

Date: _____ Patient Name: _____ DOB: _____ Age: _____ Gender: F / M

Parent Name: _____

Address: _____ Town: _____ Zip Code: _____

Parent Phone Number: _____

All questions must be answered.

1. Are you sick today?	Yes / No
2. Have you ever received a dose of COVID-19 vaccine?	Yes / No
3. If yes, which vaccine did you receive? a. Pfizer b. Moderna c. Other _____ d. Not applicable.	
4. Have you ever had a severe allergic reaction to anything? For example, a reaction for which you were treated with an EpiPen or for which you were hospitalized?	Yes / No
5. If yes, was the severe allergic reaction to after getting a vaccine or another injectable medicine?	Yes / No
6. Have you had COVID-19 infection in the last 90 days?	Yes / No
7. Have you received antibody therapy for treatment of COVID-19 in the last 90 days?	Yes/ No
8. Are you pregnant or planning to get pregnant in the next 30 days?	Yes / No
9. Do you have a weakened immune system due to disease or treatment with chemo or radiation?	Yes /No
10. Do you take a blood thinner medication?	Yes/ No

Consent

I have been given a copy of the latest Emergency Use Authorization Fact Sheet for Pfizer COVID-19 Vaccine Recipients and Caregivers. I have read and/or have had explained to me the information on COVID-19 and the Pfizer COVID-19 vaccine. I have had the opportunity to ask questions and have those questions answered to my satisfaction. I understand the risks and benefits of vaccination against COVID-19, and I request that the Pfizer COVID-19 vaccine be given to me or the person named above for whom I am authorized to make this request. I understand and agree that Public Health Solutions is not responsible for any adverse reactions that may occur and that it is my responsibility to seek medical attention for my child or myself should an adverse reaction occur.

Patient/Parent Signature: _____
(If patient is a minor, parent signature is required.)

Date:

Manufacturer: Pfizer Lot #:

Location/Route: RDIM / LDIM

Nurse Signature: _____