Flu Shots

Tuesday October 6th

PreK-12th grade

Parkers Chapel School will be offering the flu vaccine at no charge for our students. The Arkansas Department of Health nurses will be giving the vaccine. **Only shots are available. No Mist!** Information and consent forms are attached. **Please fill out all forms, front and back. Forms must be completed and turned in by Thursday October 1st.** If you have any other questions regarding the vaccines, please call the local Arkansas Department of Health at 870-863-5101 or go to www.flu.gov. If you have any questions regarding the school's permission slip, please Call the school nurse at 862-4641 ext. 114.

WE MUST HAVE BOTH FORMS BACK BY OCTOBER 1st FOR YOUR CHILD TO RECEIVE THE FLU SHOT

[Parkers Chapel School District]

SCHOOL IMMUNIZATION CLINIC
(Information in English)

Student Name:_____ Grade:_____

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S C. 1232g; 34 CFR Part 99)

I, _____, give permission for my child,
Parent, Guardian Name

_____, to participate in the
First and Last name

School Immunization Clinic. I understand that the appropriate Arkansas Department of Health consent forms will be provided for my consideration prior to the clinic.

Parent/Guardian Signature_____ Date Signed _____

CLINICA DE VACUNACION ESCOLAR
(Información en Español)

De conformidad con el Acta del Derecho a Privacidad de Familia (FERPA) (20 U.S C. 1232g; 34 CFR Part 99).

Yo, _____ le otorgo el permiso a mi hijo(a),
Padre de familia / Responsable del menor

_____, para que participe en la Clínica de
Nombre y Apellido

Vacunación Escolar. Entiendo que los formularios de consentimiento correspondientes del Departamento de Salud del estado de Arkansas me serán otorgados para verificarlos antes del la visita clínica.

Firma del Padre de Familia/ Responsable del menor _____

Fecha _____

Fight the Flu in Arkansas

Dear Parent,

Each year, in partnership with the Arkansas Department of Health (ADH), school districts hold an in-school flu immunization clinic to provide flu vaccine to their students.

If you decide to vaccinate your child during the flu vaccine clinic, please follow the instructions below.

1. Read the Vaccine Information Statement for the vaccine.
2. Read and complete the front and back of the Arkansas Department of Health (ADH) consent form.
3. PRINT clearly all information required on the ADH consent form.
4. Make sure you have signed the ADH consent form for the flu vaccine.
5. Sign the school district (FERPA) consent form (you may have signed this form at the beginning of the school year when your child was registered for school).
6. Return both consent forms to your child's school as quickly as possible.

This is a great opportunity for your child to receive the flu vaccine with no charge to you. If you have insurance, ADH will ask your insurance company to pay for the cost of giving the vaccine. If you do not have insurance or your insurance does not pay for vaccines, there will still be no charge to you.

REMEMBER, only those students with the completed paperwork (the signed ADH consent AND the school district FERPA consent) will receive the flu vaccine.

If you should have any questions or concerns about the vaccines or the ADH consent form, please contact your local health unit.

Thank you.

ARKANSAS DEPARTMENT OF HEALTH PRIVACY NOTICE-Abbreviated Version

THIS NOTICE DESCRIBES. HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO TIDS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Arkansas Department of Health (ADH) is committed to protecting your health information. ADH is required by law to protect the privacy of health information about you and that can be identified with you, which we call "protected health information," or "PHI" for short. We must give you notice of our legal duties and privacy practices concerning PHI, and we are required to abide by the terms of the notice currently in effect. This notice is to inform you about our privacy practices and legal duties related to the protection oftl1e privacy of your medical/health records that we create or receive.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

ADH staff will only use your PHI when doing their jobs. The purposes of the use and sharing of PHI are for treatment, payment for services and for Agency operations.

Treatment: Caregivers, such as nurses, doctors, therapists, nutritionists, and social workers, may use your PHI to determine your plan of care. Individuals and programs within the ADH may share PHI about you in order to coordinate the services you may need, such as clinical examinations, therapy, nutritional services, medications, hospitalization, or follow-up care.

For Payment: The ADH may release PHI about you to Medicaid, Medicare, and/or your health plan/insurance carrier to obtain payment for our services. For example, we may need to give your health plan PHI about a clinical exam or vaccinations that you or your child received, so your health plan or Medicaid or Medicare will pay us for treatment or services.

For Operations: The ADH may use and release PHI about you to ensure that the services and benefits provided to you are appropriate. For example, we may use your PHI to evaluate our treatment and service programs (quality assurance). We may combine PHI about many individuals to research health trends, to determine what services and programs should be offered, or whether new treatments or services are useful. We may share your PHI with business partners who perform functions on behalf of the ADH. For example, our business partners may use your PHI to perform case management, coordination of care, or other activities, and they must abide by the same level of confidentiality and security as ADH when handling your PHI.

YOUR HEALTH INFORMATION RIGHTS

Release of your PHI outside of the boundaries of ADH-related treatment, payment, or operations, or as otherwise permitted by state or federal law, will be made only with your specific written authorization. This authorization is required to release the following types of information: Drug and Alcohol Abuse, Family Planning, HIV/AIDS, Mental Illness, Sexually Transmitted Diseases, and Women, Infants and Children (WIC) Program. You may revoke specific authorizations to release your PHI, in writing, at any time. If you revoke an authorization, we will no longer release your PHI to the authorized recipient(s), except to the extent that the ADH has already used or released that information in reliance of the original authorization. In addition, you have the following rights:

Right to Inspect and Copy: You may request to inspect or have a copy of any part of your health record. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

Right to Request Amendment: If you feel that the PHI the ADH has created about you is incorrect or incomplete, you may ask us to amend that information. The ADH may deny your request if you ask to amend information that: I) was not created by the ADH; 2) is not part of the PHI kept by the ADH; 3) is not part of the information which you would be permitted to inspect or copy; or 4) the infom1ation is determined to be accurate and complete.

Right to Request an Accounting of Health Information Releases: You may request an accounting of disclosures of your health information. The accounting does not include disclosures for purposes of treatment, payment, health care operations; disclosures required by law for purposes of national security; disclosures to jails or correctional facilities, authorized disclosures, and any disclosures made prior to April 14, 2003.

Right to Request Restrictions: You may request ADH to limit the use or disclosure of your PHI except for treatment, payment, and health care operations. ADH is not required by law to agree to your request.

Right to Request Confidential Communication: You may request, in writing, that ADH communicate with you in a different way or to a different location, for example, using a different mailing address or calling you at a different phonenumber.

Right to a Paper Copy of this Privacy Notice: You may request a paper copy of this Privacy Notice from ADH at any time.

All requests for inspecting, copying, amending, making restrictions, or obtaining an accounting of your PHI and any questions regarding this Privacy Notice must be directed to the Local Health Unit Administrator.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the ADH by contacting the ADH HIPAA Progran1 Consultant at (501) 661-2000 or by mail by writing to 4815 West Markham, Slot 31, Little Rock, AR 72205. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. If you request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. No action will be taken against you for exercising your rights or for filing a complaint.

Sarah Huckabee Sanders
GOVERNOR

Renee Mallory
SECRETARY OF HEALTH

Jennifer Dillaha
DIRECTOR

VACCINE INFORMATION STATEMENT

A Vaccine Information Statement (VIS) is a document produced by the Centers for Disease Control and Prevention (CDC) that informs vaccine recipients – or their parents or legal representatives – about the benefits and risks of a vaccine they are receiving.

- To view the VIS for the Inactivated Influenza Vaccine (shot), go to www.cdc.gov or scan the QR code below. This link can be viewed and downloaded from your desktop, laptop, tablet, smartphone, or other web-based electronic device.

- For a paper copy of the shot VIS, you can go to your nearest Arkansas Department of Health Local Health Unit and receive a copy. Please call 1-800- 462-0599 to find out the closest health unit to you.

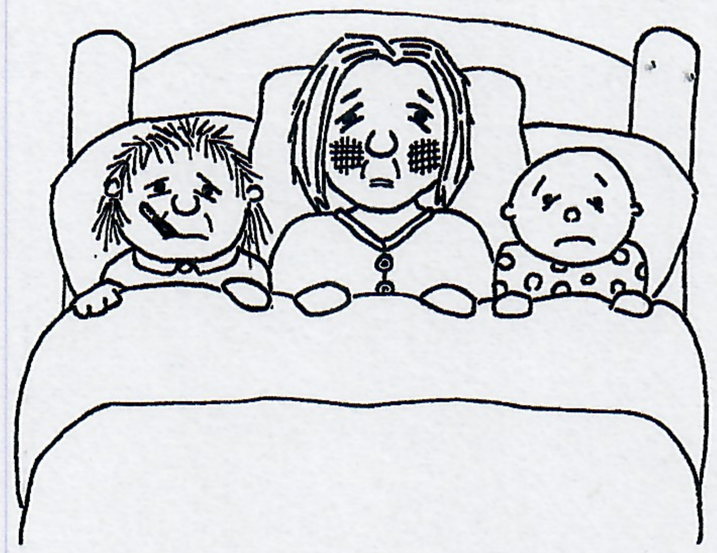
- Copies of the flu VIS will also be available at the school the day of the flu clinic.

For more information, contact the Arkansas Department of Health's Immunization Branch at 1-800-574-4040. Thank you.

ADH 05/30/2025

Arkansas Department of Health
4815 West Markham St. · Little Rock, AR 72205

Don't take chances with your family's health—make sure you all get vaccinated against influenza every year!



Here's how influenza can hurt your family . . .

Influenza can make you, your children, and your parents really sick.

Influenza usually comes on suddenly. Symptoms can include high fever, chills, headaches, exhaustion, sore throat, cough, and all-over body aches. Some people say, "It felt like a truck hit me!" Symptoms can range from mild to severe. When influenza strikes your family, the result is lost time from work and school and, possibly, doctor visits and trips to the hospital.

Influenza spreads easily from person to person.

An infected person can spread influenza when they cough, sneeze, or just talk near others. Some people might get flu by touching a surface contaminated with the flu virus and then touching their own mouth, nose, or eyes. People infected with flu don't have to feel sick to be contagious—they may even spread the flu virus to others the day before they have symptoms.

Influenza and its complications can be so serious that they can put you, your children, or your parents in the hospital—or lead to death.

Each year in the U.S., from 120,000–710,000 people are hospitalized and from 6,300–52,000 people die from influenza and its complications. The people most likely to be hospitalized and die are infants, young children, older adults, and people of all ages who have conditions such as heart or lung disease. But it's not only the youngest, oldest, or sickest who die: every year influenza kills people who were otherwise healthy.

Influenza can be a very serious disease for you, your family, and friends—but you can all be protected by getting vaccinated.

There's no substitute for yearly vaccination in protecting the people you love from influenza. Vaccination will help keep you and your loved ones safe from a potentially deadly disease. Get vaccinated every year, and make sure your children and your parents are vaccinated, too.

Get vaccinated every year! Get your children vaccinated! Be sure your parents get vaccinated, too!

Immunize.org

FOR PROFESSIONALS www.immunize.org / FOR THE PUBLIC www.vaccineinformation.org

www.immunize.org/catg.d/p4069.pdf
Item #P4069 (9/3/2025)

ARKANSAS DEPARTMENT OF HEALTH (ADH)
INFLUENZA SEASON - IMMUNIZATION CONSENT FORM

FOR ADH USE ONLY
ADH Clinic Code: _____ Date of Service: _____ AASIS Number: _____
School Name: _____ Grade: _____ LEA Number: _____

1- Person Receiving Vaccine:

Legal First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Sex: Male ☐ Female ☐ Age: _____

Telephone Number: _____

Street Address: _____ P.O. Box: _____ Apt Number: _____

City: _____ State: _____ Zip Code: _____

Race:
American Indian / Alaskan Native ☐ Black / African American ☐
Native Hawaiian / Other Pacific Islander ☐ Asian ☐ White ☐

Ethnicity:
Hispanic / Latino ☐
Non-Hispanic / Latino ☐

Insurance Status:

Insurance Company Name: _____ Member ID/ Policy Number: _____

Relationship with the Policy Holder: Self ☐ Spouse ☐ Other ☐ (If you are the policy holder, you are not required to complete the section below.)

Policy Holder Information:

Legal First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____

2- Release & Assignment: Visit the website Current VISs | Vaccines & Immunizations | CDC **to read the current influenza Vaccine Information Statement.**

- I have read or had explained to me the Vaccine Information Statement for the Inactivated Influenza Vaccine and I understand the risks and benefits.
- I give consent to ADH to vaccinate the individual named above with the flu vaccine.
- I acknowledge reviewing the ADH Privacy Notice at www.healthy.arkansas.gov, the clinic site, or with this form.
- I understand the vaccination information will be included in the ADH Immunization Registry.

To my Insurance Carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to the ADH.
- I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that a photocopy of this form may be used instead of the original.
- My signature below indicates I agree to Section 2- Release and Assignment.

Signature of Patient/ Parent/Guardian: _____ **Date:** _____

3- Medical History: Complete the following questions for the person receiving the flu vaccine.

For ADH staff: If YES is checked and further guidance is needed, notify the Regional CDNS	**Yes**	**No**
1. Do you have a fever today? (If you have fever on the day of the clinic, it may prevent you from receiving the flu vaccine.)	☐	☐
2. Have you ever had Guillain-Barré Syndrome (temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐
3. Have you ever had a serious reaction to a flu vaccine such as difficulty breathing, swelling of eyes or lips, wheezing, or immediate nausea or vomiting?	☐	☐
4. Do you have a severe allergy to any flu vaccine component, food, or medication? (i.e., gelatin, gentamicin, or neomycin)	☐	☐
5. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☐
6. Are you anxious about getting a shot today?	☐	☐
7. Are you pregnant today?	☐	☐
8. If pregnant, are you receiving prenatal care?	☐	☐

For School Clinic Use: Child's Homeroom Teacher _____

Note:
Children aged 6 months through 8 years may require a second dose. Contact your health provider or your ADH Local Health Unit in four weeks for more information.

Flu Vaccine Administration: To be completed by ADH staff only

Shot Code: 70:Trivalent (P-F) ≥ 6 months ☐ 72: Trivalent (P-F) ≥ 65 years ☐

Flu Vaccine: Route IM: ☐

Site Code: _____ Dosage mL: _____ MFG Code: _____ Lot Number: _____

Site Codes

Right Deltoid (**RD**) Right Leg (**RL**)
Left Deltoid (**LD**) Left Leg (**LL**)

MFG Codes

GlaxoSmithKline (**SKB**) Sanofi (**PMC**)
MedImmune (**MED**) Seqirus (**SEQ**)

Signature Vaccine Administrator/Title: _____ **Date Vaccine Administered:** _____

FORM 4056

Revised 6/11/2026