GEORGIA DEPARTMENT OF PUBLIC HEALTH
Southeast Health District

Southeast Health District
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www.sehdph.org

Rosemarie D. Parks, M.D., M.P.H.
District Health Director

FLU VACCINE AT SCHOOL

Dear Parent/Guardian:

The best way to keep our students healthy during flu season is to immunize them against the influenza virus.

Your Local County Health Department will schedule voluntary flu vaccination clinics at local schools in the upcoming weeks. All enrolled students will be eligible to receive the flu vaccine, with parental consent. These clinics will be set up with minimal interruption to the school day. The nasal spray form of the vaccine *will not* be offered this year.

The flu vaccine provided will be **Inactivated Trivalent Influenza Vaccine (TIV)**; flu vaccine **given as a *shot*.**

For more information on flu vaccine, please see the attached "What You Need to Know" Vaccine Information Statement.

All children are eligible to participate regardless of insurance status. If your child has health insurance that covers vaccines, please provide the child's insurance information and a copy of the insurance card. *If your insurance does not agree to pay the fee or you do not have insurance, we will not charge you or your insurance.*

If you would like to have your child vaccinated during the school-based flu clinic please:

1) **Read the "What You Need to Know" Vaccine Information Statement included with this letter.**
2) **Fully complete, sign, and date the attached consent form.**
3) **Return the consent form to the school as soon as possible – no later than 1 week after receiving this packet.**

Please do not return the form if you do not wish to have your child vaccinated.

School staff will let you know when the flu vaccine clinic will take place at your child's school (between late September – early November).

If you wish to withdraw consent at any time before the school clinic, please contact the school/school nurse.

Depending on whether they've received influenza vaccines in the past, children under age 9 may need a second dose approximately one month after the first dose. *If your child needs a second dose*, we will send home another consent form for you to complete and sign before the second dose is given.

If you have any questions about the vaccine or the vaccination clinics, please contact ***your local Health Department***

OR: **Synita Mathis, DNP, RN, CLC**
Southeast Health District Immunization Coordinator
1-855-473-4374 (Call Center)
Synita.Mathis@dph.ga.gov

Your child's health care provider can also answer your questions regarding the influenza virus and can give your child the seasonal influenza vaccine.

Your healthcare information is protected. You can view a copy of our HIPAA Notice of Privacy Policy by going to www.sehdph.org/our-counties and selecting your county of residence.

Thank you for helping keep our students safe and healthy.

VACCINE INFORMATION STATEMENT

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

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 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.

In an average 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.

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CDC recommends everyone 6 months 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 the influenza viruses believed to be 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.

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Tell your vaccination 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 until a future visit.

Influenza vaccine can be administered at any time during pregnancy. Women who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

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. CENTERS FOR DISEASE CONTROL AND PREVENTION

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- 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 members 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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. 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.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at www.fda.gov/vaccines-blood-biologics/vaccines.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at www.cdc.gov/flu.

2026-2027 School-Based Influenza Vaccine Consent Form

Southeast Health District

SCHOOL NAME: _____

If you do NOT want your child to receive flu vaccine at school, please do NOT fill out this form.

Section 1: Information about Student to Receive Influenza Vaccine *(please print)*

FIRST NAME	MIDDLE INITIAL	LAST NAME	NICKNAME (Name student goes by):	
DATE OF BIRTH (mm/dd/yyyy)	AGE	GENDER: *(Please Circle)* Male Female	HOMEROOM TEACHER	GRADE
ETHNICITY *(Please Check)* Hispanic/Latino ☐ Yes / ☐ No	RACE *(Please Circle)* African American/Black White Asian American Indian or Alaska Native Native Hawaiian or Other Pacific Islander Other		PARENT/LEGAL GUARDIAN'S NAME	
HOME ADDRESS			PARENT/GUARDIAN PHONE NUMBER(S)	
CITY	STATE	ZIP CODE	*Provide insurance plan information below. *Name of Policy Holder/Name on ID Card:* _____ *Member ID#:* _____ *Group#/Policy Type (HMO, PPO, CMO):* _____ *Please attach a copy of the insurance card to this form.*	

INSURANCE INFORMATION: Does your child have insurance that covers vaccines? ☐ Yes / ☐ No

If "Yes," please check health insurance provider below & complete the information to the right*:

☐ Aetna ☐ Medicaid/Amerigroup/Peachstate/Wellcare/CareSource

☐ Peachcare for Kids ☐ Blue Cross/Blue Shield/Anthem

☐ Cigna ☐ United Healthcare

☐ Coventry ☐ Other_____ ☐ No insurance coverage

Section 2: Medical Information

The following questions will help us to determine if this student can receive the influenza vaccine. Please circle Yes or No for every question.

1.	When was the student last vaccinated for flu (if known)?	DATE:	
2.	Has the student ever had a serious allergic reaction to eggs?	Yes	No
3.	Has the student ever had a serious reaction to any influenza (flu) vaccine?	Yes	No
4.	Has the student ever had Guillain-Barré Syndrome (GBS)?	Yes	No

Section 3: Consent to vaccinate

*If this consent form is not filled out completely, signed, dated, and returned, the student **will not** be vaccinated at school.*

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE

By signing below, I acknowledge that the student and medical information provided above is correct. I have received a copy of the VACCINE INFORMATION STATEMENT for INFLUENZA VACCINE and the NOTICE of PRIVACY POLICY FORM. I was given the opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine that will be given to the student above. I understand that participation and receipt of the influenza vaccine through this program is completely voluntary.

By signing below, I give consent for the student listed above to receive flu vaccine at school.

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

FOR CLINIC USE ONLY

VIS: Inactivated Influenza Vaccine 1/31/2025

Administration Route: ☐ IM / LEFT Deltoid ☐ IM / RIGHT Deltoid

Mfg: _____

Lot #: _____

Exp Date: _____

_____

NURSE SIGNATURE

_____

DATE

Demographic/insurance information entered/updated by: _____ **Date:** _____

PUBLIC $PRIVATE$ **PIN#:**