

Chariton County Health Center

206 State Street

Keytesville, MO 65261

Ph: (660) 288-3675 - Fax: (660) 288-3725

Dear Parent/Guardian,

Depending on availability, the Chariton County Health Center (CCHC) will be providing flu vaccine for students in the fall of 2023. This is not a vaccine for COVID-19. CCHC will give the flu vaccine to students that have completed parent/guardian permission. The nurse will give the vaccine during school hours.

Vaccination is one of the best ways to protect your child and family. CCHC is working to immunize as many children as possible. With the exception of some children with certain health conditions, most can receive the vaccination. Please read the current information sheet for both the Flu Mist (*Influenza-live intranasal*) and injection (*Influenza-inactivated*) at <https://www.cdc.gov/vaccines/hcp/vis/current-vis.html>. CCHC will provide a written copy of the vaccine information sheets on request.

FluMist does not require a shot. The nurse gives the vaccine by a quick spray in each nostril. FluMist is a weakened live virus vaccine.

The flu shot will also be available. Some students are not able to take the FluMist due to medical conditions or they may prefer the flu shot. The flu shot is not a live vaccine. The nurse administers the flu shot in the arm or thigh depending on the age of the child.

If you would like your student to receive the flu vaccine, please complete the attached form. Your insurance will be billed. If you do not have insurance, please indicate this on the form. If you have no insurance, you are still eligible to receive the vaccination.

If you are interested in the vaccination, please return the signed permission form to the school nurse by **September 29, 2023.** Vaccines are **tentatively** scheduled to be given on **November 3**.

Sincerely,

Michelle Schiltz, RN, BSN

**Flu Permission and Insurance**

**Complete the following information only if you want your student to receive the flu vaccination**. Complete a separate form for each student. *This information is required to file insurance*.

Grade: \_\_\_\_\_\_ Full Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I prefer my student receive: Flu Mist (administered nasally) Flu Shot**

*Insurance:*  Insurance: Yes No (If possible send a copy of the card)

Exact name of insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder's full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder's date of birth: \_\_\_\_\_\_\_\_\_\_

Policy holder's gender: Male Female Student's Relationship to policy holder: Self Dependent

Member ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Screening Questions:

Has your student had a previous reaction to flu vaccine? No Yes (Explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your student had a recent illness or elevated temperature? No Yes (Explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your student have any allergies? No Yes Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for Chariton County Health Center to administer the flu vaccination to my student at school. I have read the Influenza Vaccine Information Sheet and had questions answered to my satisfaction. I understand the benefits and risk of the vaccine. I authorize administration of the flu vaccination to my child. I understand that the confidentiality of this health information will be maintained as required by applicable state and federal laws. I consent to Insurance or Medicaid billing if applicable.

***Parent/Guardian Signature***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

For Office Use Only

Nurse Administrator\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_

FluMist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Route Internasal

Flu Shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Route IM

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VIS Date: