Dear Parent/Guardian:

Flu vaccinations are coming to your child's school. They will be given at NO CHARGE TO YOU. Now, more than ever, it is important to protect your family through vaccinations.

If you would like your child to be vaccinated, **BEFORE Friday, October 1:**

Fill out the consent form online at:
https://tinyurl.com/HCPSFlu

1. Type your child's school name in **Search by Name** then press the blue **Search** button.
2. Click on the **Sign Up for Childhood Vaccinations** button for your child's school.

OR

Fill out a paper consent form:

1. Read the Vaccine Information Statement (VIS) and talk to your health care provider or the school nurse about any questions you have. VIS: https://tinyurl.com/FluVIS2021-E
2. Fill out every section of the attached Consent Form.
3. Use your insurance card to fill out your insurance information accurately. Your insurance company will be billed. **There is no co-pay or deductible.** You will NOT be charged by us or your insurance company.

Influenza, also known as the flu, is a serious illness that affects people of all ages. One of the best ways to prevent the flu is through vaccinations. We are pleased to join with the Maryland Partnership for Prevention (MPP) to offer flu vaccinations at our school.

You may give permission for your child to be vaccinated using (1) an online form at https://tinyurl.com/HCPSFlu or (2) the hard copy form attached to this message.

We urge you to protect your family from the flu. The Centers for Disease Control and Prevention (CDC) recommends that everyone ages 6 months and older get a flu shot. Please visit www.cdc.gov/flu/index.htm for more information about the flu vaccine.

Thank you!

Harford County Public Schools and Maryland Partnership for Prevention

School Nurse

HARFORD COUNTY Public Schools Consent Form for SY 2021-22 Flu Clinic

Please Print Clearly in Ink

Fill out this section

Student's LAST Name	Student's FIRST Name	M.I.	Student's Birthdate / /	Age	Gender F M Other	Grade
Parent/Guardian LAST Name	Parent/Guardian FIRST Name	M.I.	Cell/Daytime Phone			
Address			Email Address			
City	ZIP Code		School Name		Teacher/Homeroom	

Fill out this section

HEALTH INSURANCE INFORMATION – PLEASE FILL OUT COMPLETELY AND ACCURATELY

Please copy this information from YOUR INSURANCE CARD. We will bill your insurance. <u>You will NOT be charged</u> a co-pay or a deductible.

Type of Insurance: ❒ **Medical Assistance/Medicaid** ❒ **Private Insurance** ❒ **My child does not have health insurance**
(Your child will not be turned away because of no insurance)

INSURANCE COMPANY NAME	Member ID Number (write in boxes below)
	Group Number

FOR **PRIVATE INSURANCE** ONLY

Policy Holder's/Insured Adult's Name	Relationship to Student	Insured Adult's Birthdate / /	Any Other # from Insurance Card

Answer these

1. Do any of the following apply to your child? ***(If you answer YES to any question, your child might not be vaccinated.)***

Yes	No		Yes	No	
❒	❒	Has had a serious reaction to a flu vaccine in the past?	❒	❒	Has had Guillain-Barre syndrome?
❒	❒	Has an allergy to a component of the flu vaccine?			

If your child is under 9 years old and has not had a flu vaccination before, she/he may need a second flu vaccination this year. Please check with your health care provider to see if your child needs a second "dose" of the vaccine.

If you have any questions about flu vaccine, please contact your child's doctor or the health department or go to <u>www.flu.gov</u>.

CONSENT FOR VACCINATION(S) – YOU MUST SIGN HERE FOR YOUR CHILD TO BE VACCINATED

By signing this form, I give permission for my child to be vaccinated, my insurance company to be billed for the service, and the vaccinaction to be entered into ImmuNet, and Maryland's immunization registry. Further, I agree that:
(1) The information above is correct; (2) I have read the Vaccine Information Statement dated 8/6/21 or someone has read it to me;
(3) I understand the risks and benefits of getting the vaccine I have consented for my child to receive; and
(4) Any questions I had about the vaccine(s) have been answered;

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

FOR OFFICE USE ONLY				
Date of Administration / VIS Given	Vaccine	Vaccine Manufacturer	Lot Number	PRINT Name of Vaccine Administrator