MOUNTAIN HOME PUBLIC SCHOOLS
2465 RODEO DRIVE
MOUNTAIN HOME, ARKANSAS 72653
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Dr. Charles Scriber
SUPERINTENDENT OF SCHOOLS

John W. Calaway
ASSISTANT SUPERINTENDENT

INACTIVATED INFLUENZA VACCINE (SEASONAL FLU)

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

I, ________________________________, give permission for my child,

____________________________, to participate in the Seasonal Flu Immunization Clinic.

Parent/Guardian Signature____________________________________ Date:____________

- -

PANDEMIC H1N1 2009 (SWINE FLU)

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

I, ________________________________, give permission for my child,

____________________________, to participate in the Pandemic H1N1 (Swine Flu) Immunization Clinic.

Parent/Guardian Signature:______________________________ Date:________________

2009 INFLUENZA IMMUNIZATION REPORTING FORM

ARKANSAS DEPARTMENT OF HEALTH
4815 West Markham St. SLOT # 48
Little Rock, AR 72205-3867
Tel: (501) 661-2169
Fax: (501) 661-2300

School Grade: ____________

ADH Clinic Code:
School INC PIN
Date Vaccine Administered: __ __ / __ __ / __ __ __ __

1. Patient Information

Last Name (apellido)

First Name (nombre) **MI**

Gender (género): ☐ Male ☐ Female

Date of Birth (fecha de nacimiento) __ __ / __ __ / __ __ __ __

Race (raza y pertenencia étnica):
☐ White Non-Hispanic ☐ Hispanic ☐ Asian/Pacific Islander
☐ Black/African American ☐ Native American/Alaskan Native ☐ Unknown

Address: (dirección) **Apt. No.** (número de apartamento)

City (ciudad) **State** (estado) **Zip Code** (código postal)

Phone Number (teléfono) ___ - ___ - ____

2. Insurance Status (Check appropriate box): (estado de seguros, Compruebe la caja apropiada):

☐ Medicaid/ARKids Number (número de seguro de enfermedad)
☐ Medicare Number (número de asistencia médica)
☐ Name of Insurance: ______________________ State Employees Insurance (Employee Benefit Division) ☐ Yes ☐ No

Insurance ID Number (Número de identificación de seguro):

Insurance Group Number (Número de Grupo de Seguros)

☐ No Insurance (Ningún Seguro) ☐ Underinsured *(no totalmente asegurado)* (insurance does not pay full amount for vaccine)

3A. Medical History For Seasonal and H1N1 Injectable Flu Vaccine *(La Historia Médica):*
Complete the following questions for the individual receiving the vaccine. ***(Complete las siguientes preguntas por la persona que va a recibir la vacuna.)***

	YES	NO
• Have you ever had a serious allergic reaction to eggs? ○ *Alguna vez ha tenido usted una reaccion seria de alergia a huevos?*		
• Have you ever had a serious reaction to a previous dose of flu vaccine? ○ *Alguna vez ha tenido usted una reaccion seria a dosis anteriores de la vacuna antigripal?*		
• Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? ○ *Alguna vez ha tenido usted el Sindrome de Guillain-Barré (un tipo de debilidad severa de musculos despues de recibir una vacuna antigripal?*		

Name:______________________________ Date of Birth:______________________

3B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two vaccines (injectable or intranasal) you can get. ***(Hay dos clases de vacuna de influenza H1N1 2009. Sus respuestas a las siguientes preguntas nos ayudara a conocer cuales de las dos clases de vacunas puede recibir).***

	YES	NO
• Have you been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: ______________________ Date given: month______day_______year__________ o *(Ha sido usted vacunado con cualquier vacuna (no solo antigripal) dentro de los ultimos 30 dias?* *Vacuna: Fecha dada: mes dia año)*		
• Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? o *(Tiene usted alguno de los siguientes: asma, diabetes (u otro tipo de enfermedad de matabolismo), o enfermedad de pulmones, corazon, riñones, higado, nervios, o sangre?)*		
• Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)? o *(Esta usted en una terapia a largo-plazo de aspirina o conteniendo-aspirina (por ejemplo, toma usted aspirina diario)?)*		
• Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? o *(Tiene usted un sistema inmunológico débil (por ejemplo, de HIV, cancer, o medicinas como esteroides o esos usados para tratar el cancer?)*		
• Are you pregnant? o *(Esta usted embarazada?)*		
• Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)? o *(Tiene usted contacto cercano con una persona que necesita cuidado en un ambiente protegido (por ejemplo, alguien que recientemente tuvo un transplante de médula espinal?)*		

4. Release and Assignment *(Publicar y Asignar)*

- I have read or had explained to me the 2009-2010 Vaccine Information Statement for the Inactivated Influenza Vaccine (8/11/09) and for the 2009 H1N1 Influenza Vaccine ( ) and understand the risks and benefits.
  - *He leído o me han explicado la Declaración de la Información de la Vacuna para la Vacuna de Influenza Inactivada del 2009-2010 (8/11/09) y para la Vacuna de Influenza H1N1 del 2009 ( ) y he entendido los riesgos y beneficios.*
- I give consent to the State/Local Health Department and its staff for the individual named at the top of this form to be vaccinated with one or both of these vaccines.
  - *Yo doy mi consentimiento al Departamento de Salud Local/Estatal y a su personal para que el nombre descrito arriba de esta forma sea vacunado con una o ambas vacunas.*
- I hereby acknowledge that I have reviewed a copy of the Arkansas Department of Health's Privacy Notice.
  - *Yo, por la presente reconozco que he revisado una copia de la Nota de Privacidad del Departamento de Salud de Arkansas.*

To My Insurance Carrier(s): *(Para Mi Portador de Aseguranza(s)):*

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
  - *Yo autorizo la liberacion de cualquier informacion medica necesaria para el proceso de reclamo(s) de mi aseguranza.*
- **I authorize and request payment of medical benefits directly to the Arkansas Department of Health.**
  - *Yo autorizo y solicito pago de beneficios medicos directamente al Departamento de Salud de Arkansas.*
- **I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.**
  - *Yo estoy de acuerdo que la autorizacion cubrira todos los servicios medicos otorgados hasta que dicha autorizacion sea revocada por mi.*
- **I agree that the photocopy of this form may be used in lieu of the original.**
  - *Yo estoy de acuerdo que la fotocopia de esta forma puede ser usada en lugar de la original.*

Signature of Patient/Parent/Guardian for **seasonal flu** (Firma): ______________________ Date: __________

Signature of Patient/Parent/Guardian for **2009 H1N1 vaccine** (Firma): ______________________ Date: __________

Consent Valid Through June 30, 2010

Name:______________________ Date of Birth:__________________

SHOT CODE:

☐ 48: Preservative Free (P-F) 6- 35 months

☐ 59: Preservative Free (P-F) ≥ 3 years

☐ 39: Intranasal vaccine. Preservative Free (P-F) 2 through 49 years

Site Codes: Right Arm = RA, Right Leg = RL, Left Arm = LA, Left Leg = LL

Seasonal Flu Vaccine	Route	Site Code	Dosage mL.	MFG Code	Lot Number	Signature /Title of Vaccine Administrator
	☐ IM ☐ Intranasal					

☐ 66:H1N1 Injectable ☐ 67:H1N1 Intranasal

2009 H1N1 Flu Vaccine	Route	Site Code	Dosage mL.	Dose Number (1st or 2nd)	MFG Code	Lot Number	Signature /Title of Vaccine Administrator
	☐ IM ☐ Intranasal						
		If Adjuvant, enter Lot number					

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 THIS 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 of the 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: 1) 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 information 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 phone number.

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 Program 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.

Imm-Flu Rev 9/09

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