

City of Newton



Setti D. Warren
Mayor

HEALTH AND HUMAN SERVICES DEPARTMENT

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Public Health
Prevent. Promote. Protect.

September 9, 2015

Dear Parents/Guardians:

The Health and Human Services Department is once again pleased to offer the influenza vaccine to all Newton students in Kindergarten through grade 12.

Both the flu shot and the flu nasal spray vaccine will be administered during the school day at no charge to families. The flu vaccination program is free again this year because the Massachusetts Department of Public Health is providing the flu vaccine for students, but we do request insurance information to help recoup costs to administer the vaccine.

Clinics will be held in each Newton public school from late September through mid-November. Specific clinic dates will be announced at each school and are posted online at www.newtonma.gov/flu

To sign your child up, you should return two forms to the school nurse no later than 2 school days before the clinic date at your child's school:

- 1. Consent/Screening Form**
- 2. Student Vaccine Administration Record/Insurance Information Form**

- Forms are available online at www.newtonma.gov/flu or in the school nurse's office.
- Students who are not signed up will not receive the vaccine.
- The Consent/Screening form requires parents to choose either the flu shot or the nasal spray flu vaccine. Information about each type of vaccine, including its risks and benefits, is described on the Vaccine Information Statement posted at www.newtonma.gov/flu School nurses also have information and can answer any questions.
- The Centers for Disease Control and Prevention (CDC) recommends the flu vaccine for everyone 6 months and older.

Every year children are at risk of developing serious complications from influenza. Flu vaccination is one of the best ways to protect children from getting the flu. We hope you take advantage of this important prevention program.

Sincerely,

Ruth Hoshino, RN
Director of School Health Services

David Fleishman
Superintendent of Schools



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Student Flu Vaccine Consent and Screening Form 2015-16

Child's Last Name	Child's First Name	Date of Birth	Age	Gender: M F
Parent/Guardian Last Name	Parent/Guardian First Name		Parent/Guardian Daytime Phone	
School Name	Teacher (K to 5th grade) OR Team (6th to 8th grade) Leave blank for 9th-12 graders		Grade	

Select either flu shot or nasal spray.

- Answer the screening questions only for that type of vaccine.
- Sign below those screening questions.
- A "YES" to any question (except #12) indicates your child cannot receive that type of vaccine. If you are not sure of the answers to these questions, contact your child's health care provider.

Check **ONE** box below for the vaccine you want your child to receive.

FLU SHOT

OR

NASAL SPRAY

	Yes	No
1. Does your child have a problem eating eggs?		
2. Does your child have an allergy to gentamicin, neomycin, polymixin or gelatin?		
3. Has your child ever had a serious reaction to a flu vaccine in the past?		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

	Yes	No
1. Does your child have a problem eating eggs?		
2. Does your child have an allergy to gentamicin, neomycin, polymixin or gelatin?		
3. Has your child ever had a serious reaction to a flu vaccine in the past?		
4. Does your child have asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
5. If your child is younger than 5 years old, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months?		
6. Does your child have a weak immune system (from HIV, cancer, or medicines such as steroids or those used to treat cancer)?		
7. Is your child taking antiviral medications?		
8. Does your child take aspirin or aspirin-containing medicine every day?		
9. Is your child pregnant?		
10. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
11. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		
12. Has your child received any other vaccinations (not just flu) in the past 30 days? Vaccine: _____ Date: ____/____/____		

I have read the 2015-2016 Vaccine Information Statement for the flu shot and understand the risks and benefits.
I GIVE CONSENT for my child to get vaccinated with this vaccine.
PARENT/GUARDIAN SIGNATURE: _____
DATE: _____

I have read the 2015-2016 Vaccine Information Statement for the nasal spray and understand the risks and benefits.
I GIVE CONSENT for my child to get vaccinated with this vaccine.
PARENT/GUARDIAN SIGNATURE: _____
DATE: _____

For all children 6 months through 8 years old:
Children in this age group should receive 2 doses of the 2015-2016 seasonal influenza vaccine at least 4 weeks apart unless they received:
• At least 2 doses of any seasonal influenza vaccine prior to July 1, 2015
Contact the child's primary health care provider to receive a second dose, or visit www.newtonma.gov/flu for additional clinics.

Massachusetts law (M.G.L. c. 111, Section 24M) requires providers to report immunization information to a computerized immunization registry known as the **Massachusetts Immunization Information System (MIIS)**. The MIIS stores immunization records for you and your healthcare provider and can help prevent outbreaks of disease like measles and the flu. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask your healthcare provider, visit the MIIS website at www.mass.gov/dph/miis or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.

Student 2015-2016 Insurance Information Form & Vaccine Administration Record

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: *	Age*	Sex: (Circle)*
	_____ Month Day Year		Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:*
			()

Insurance Information: Include the whole member ID number and any letters that are part of that number

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
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If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: *	Sex: (Circle)*
	_____ Month Day Year	Male Female
Subscriber's Street Address: * (If different from address above)		
City:*	State:*	Zip: *
		()
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

For children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:

Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)

Does not have health insurance

Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:

Has health insurance and is not American Indian (Native American) or Alaska Native

I give permission for my insurance company to be billed.

X _____ Date: _____
(Signature of patient, parent or legal guardian)

For Clinic/Office Use Only:

Signature of Vaccine Administrator: _____

Date of Service	Vax Type	Vaccine Mfrgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV4				0.5	Yes	Yes No	IM	R Arm L Arm	8/7/15	9/9/15
	LAIV4	Med-Immune			0.2	Yes	Yes	Intranasal	NA	8/7/15	9/9/15