



**HEIDELBERG HIGH SCHOOL
INFLUENZA VACCINATION CLINIC – 26 SEP 2012
One Day Only
Bring PERMISSION FORMS on the day 26 SEP 2012**



MEMORANDUM FOR HHS PARENTS/GUARDIANS

SUBJECT: Flu Mist & Influenza Vaccine Immunization Clinic on 26 SEP 2012 at HHS

FROM: Kevin J. Brewer Principal, HHS

*Reference: Armed Forces Joint Instruction 48-110 (AFJI 48-110)
Immunizations and Chemoprophylaxis September 29, 2006*

The DoD policy concerning immunizations as outlined in the AFJI 48-110 mandates Department of Defense schoolteachers, daycare center workers, and children attending DoD-sponsored schools and daycare centers or similar facilities on military installations, as a condition of employment or attendance at these facilities, be administered appropriate vaccines against communicable diseases unless medically or administratively exempt. In response to guidance received from the Command Surgeon, US European Command, the seasonal influenza immunization will remain a requirement for enrollment in DoDDS-E schools for 2012-2013 school year.

The Heidelberg Health Clinic is offering your student the opportunity to receive this vaccine at Heidelberg High School on **26 SEP 2012 ONLY**

- If your student is high risk, i.e. has **ASTHMA, Diabetes, latex allergy, or other health conditions**, and needs the injection, they can receive the vaccine at this school-based clinic. You may also take your child to the HD Clinic or the Immunization Clinic at the Heidelberg Clinic.
- If your student is **ALLERGIC to EGGS**, please note this information below- with screening clearance your student may be able to receive the approved vaccine for those with egg allergies. If you have a question about this new information- see your medical provider prior to 26 SEP.
- If you plan for your student to receive the flu mist or injection at the HHS immunization clinic on 26 SEP, please complete, sign and return both the Permission form and the Pediatric/Adolescent Screening Form with the sponsor's social security number recorded where indicated. In addition, it is important to carefully read the information sheets about the flu mist or injection.
- If you do not wish for your child to participate in this vaccination clinic, please complete the corresponding section below and return this form along with the completed DoDEA Waiver if needed to Nurse Leipheimer by 6 OCT.

-----**COMPLETE AND BRING THE PERMISSION FORM BELOW & THE SCREENING FORM**-----

Complete and return this document and the HD Screening form to the HHS on 26 SEP 2012

Student's last name	first name	Birth Date	Current AGE
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My signature below indicates that I have read the above and give my permission for my child to receive the following administered by the Heidelberg Medical Clinic:

- | | |
|--|---|
| <input type="checkbox"/> Flu mist | <input type="checkbox"/> We plan to get the vaccine with our medical provider and <u>provide documentation to the School Nurse by 24 OCT 2012</u> |
| OR | |
| <input type="checkbox"/> Influenza Vaccine injection | <input type="checkbox"/> Decline the vaccine and <u>submit the DoDEA Waiver</u> |

List your Child's Allergies or any health issues _____

Preferred Contact Number on 26 SEP: c/w/h: _____

Print Sponsor/Parent Name	Signature	Sponsor Last 4 SS #
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STUDENTS MAY BRING THEIR YELLOW IMMUNIZATION CARD ON 26 SEP 2012 TO DOCUMENT VACCINATION

2012-2013 Pediatric and Adolescent Influenza Screening Questionnaire

This printed material contains sensitive PII protected under the Privacy Act which is FOR OFFICIAL USE ONLY and must be protected in accordance with the Privacy Act, 5 USC § 552a. Unauthorized disclosure or misuse of this SENSITIVE PII may result in criminal and/or civil penalties

Recipient's Name: (last, first)	Date of Birth: (month/day/year)	Sponsor's SSN:
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Sponsor's Service: Army Air Force Navy/Marine Corps	Sponsor's Status: Active Duty Reserve/NG Dependent Civilian Retired
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1.	Is your child younger than 2 years of age?	No	Yes
2.	Has your child ever received a seasonal influenza vaccine?	No	Yes
3.	Does your child currently feel sick or have a fever?	No	Yes
4.	Has your child ever had a serious reaction to a flu vaccination in the past?	No	Yes
5.	Does your child have a history of Guillain-Barré Syndrome (GBS)?	No	Yes
6.	Does your child have allergy to any of the following: eggs, egg protein, MSG, gentamicin, neomycin, polymyxin, gelatin, arginine, thimerosal, formaldehyde, or vaccine components?	No	Yes
7.	Is your child taking any prescription medicines to prevent or treat influenza? Have they taken any antivirals in the last 48 hours?	No	Yes
8.	Is the adolescent to be vaccinated pregnant?	No	Yes
9.	Does your child have a history of asthma, reactive airway disease, or wheezing?	No	Yes
10.	Does your child have heart disease, lung disease, kidney disease, liver disease, neurological or neuromuscular disease, metabolic disorders (e.g., diabetes), blood disorder or any other chronic health conditions?	No	Yes
11.	Does your child have a weakened immune system because of HIV or another disease that affects the immune system; take long-term high dose steroid treatments; or cancer treatment with radiation or drugs?	No	Yes
12.	Does your child live with or expect to have contact with severely immunocompromised individuals who must be in a protective environment (those in isolation)?	No	Yes
13.	Has your child received any vaccines within the last 30 days or are they going to receive any additional vaccines within the next 4 weeks?	No	Yes
14.	Is your child taking aspirin or aspirin-containing products?	No	Yes

*I have read, or have had explained to me, the information in the 2012-2013 Influenza Vaccine Information Sheet (VIS). I have also had a chance to ask any questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine.
(This form is subject to the Privacy Act of 1974)*

Recipient's signature _____ Date _____

Below to be completed by healthcare provider only

<input type="checkbox"/> Give injectable flu vaccine today	Comments:
<input type="checkbox"/> Give intranasal flu vaccine today	Interviewer's Signature:
<input type="checkbox"/> Do NOT administer flu vaccine today	

Vaccine Administered

<input type="checkbox"/> Live Intranasal FluMist	<input type="checkbox"/> Inactivated Influenza Fluzone Shot (Infant/Toddler)	<input type="checkbox"/> Inactivated Influenza Fluzone Shot (Toddler/Preschooler)	<input type="checkbox"/> Inactivated Influenza Afluria Shot (Pre-schooler/Adult) <i>** May be used for 5 yrs and older if no other vaccine is available per ACIP guidelines</i>
Ages: 2yrs - 4yrs Dose: 0.2ml	Ages: 6 months - 35 months (2-9yrs) Dose: 0.25ml Route: IM: L / R: Deltoid	Ages: 6 months - 6yrs Dose: 0.5ml Route: IM: L / R: Deltoid	Ages: 9 yrs and older** Dose: 0.5ml Route: IM: L / R: Deltoid
Lot # _____	Lot # _____	Lot # _____	Lot # _____
Administered by: _____		Date: _____	