



615 Martin Luther King Jr. Blvd • Bristol, TN 37620
(423) 652-9451 • Fax (423) 652-9238 • www.btcs.org

September 2020

Dear Parent/Guardian,

According to the Centers for Disease Control and Prevention (CDC), it is likely that flu viruses and the virus that causes COVID-19 will both spread this fall and winter. Therefore, getting an influenza vaccine (flu shot) is more important than ever.

The Sullivan County Regional Health Department will offer influenza vaccinations to all students in Bristol Tennessee City Schools at each school location. If you would like for your child to be vaccinated, please complete, sign, and return the attached **Consent Form** to your child's school no later than September 28, 2020, so that the Health Department can appropriately plan.

The dates of the vaccination clinics are not known at this time. After Consent Forms are returned, the health department will order the appropriate number of vaccines, and the vaccination dates will be scheduled. Children under the age of nine or children receiving the vaccine for the first time should receive two (2) doses at least four (4) weeks apart. Parents would be required to contact the Sullivan County Health Department to schedule the second vaccine.

*The Sullivan County Regional Health Department will not vaccinate your child unless you return a completed, signed **Consent Form**.*

If you have any questions about the seasonal flu or flu vaccinations, we encourage you to call your doctor's office or the Sullivan County Regional Health Department at (423) 279-2777. Additional information is also available at the following websites:

<https://www.sullivanhealth.org>

<https://www.cdc.gov/flu/index.htm>

<https://www.tn.gov/health.html>

Sincerely,

A handwritten signature in cursive script that reads "Annette Tudor".

Annette Tudor, Ed.D.
Director of Schools

ENGAGE. CHALLENGE. INSPIRE.



PLEASE READ BEFORE COMPLETING THIS FORM.

Only complete the following consent form if you wish for your child to receive a flu injection.

If you have any questions please call the Sullivan County Regional Health Department at 423-279-2777

DO NOT return this consent form if your child will not be receiving the flu injection.



Sullivan County Regional Health Department Flu Vaccination Program for Schools 2020-2021

PLEASE PRINT		
IMPORTANT!!! PHONE NUMBERS WHERE PARENT/GUARDIAN CAN BE REACHED DURING SCHOOL HOURS:		
Work: _____	Cell: _____	Home: _____
Student Information		
Last: _____	First: _____	MI: _____ Date of Birth: _____ Sex: M or F
Address: _____		City: _____ Zip: _____
Social Security #: _____		Race (Circle one)
Sullivan County Regional Health Department 423-279-2777		Caucasian Hispanic Non-Hispanic American Indian Alaska Native Other
School: _____	Homeroom Teacher: _____	Grade: _____
<p>Please circle Yes or No to all of the questions below to determine if your child can receive the Inactivated Influenza Vaccine ("flu shot"). The nurse giving the vaccine will review this information on the day the vaccine is given.</p>		
Has your child ever had a serious allergic reaction to any component of any flu vaccine (eggs, gentamicin, gelatin, arginine)?	Yes	No
Has your child ever had a serious reaction to any component of any flu vaccine in the past?	Yes	No
Has your child ever had Guillain-Barre syndrome?	Yes	No
Does your child have any allergies? If yes, please list:	Yes	No
Is your child under 9 years of age?	Yes	No
<p>(If your child is less than 9 years of age and has never been vaccinated against the flu or has not been vaccinated with at least 2 doses of seasonal influenza vaccine before July 1, 2015, your child will require 2 doses this year. Please wait four weeks and call the Sullivan County Health Department to schedule this second dose of the Influenza vaccine.)</p>		
<p>I have read the 2017 Vaccination Information Statement for the Inactivated Influenza Vaccine (flu shot), I understand the risks and benefits, and I give consent to the Sullivan County Health Department and it's authorized staff for my child named at the top of this form to receive the inactivated injectable influenza vaccine (shot).</p>		
<p>Request for Administration of Influenza Vaccine for the above named recipient: I will receive information about the vaccine and special precautions on the Vaccine Information Sheet prior to my child receiving and on the day of vaccination. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release the City of Kingsport, Kingsport city Schools, the City of Bristol, Bristol City Schools, Sullivan County employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.</p>		
<p>I understand that this document will be given to and retained by the public health department. I give my permission for my child's school to retain a copy if needed.</p>		
Signature of Parent/Legal Guardian _____		Date: _____
Print Parent/Legal Guardian: _____		



Sullivan County Regional Health Department Flu Vaccination Program for Schools 2020-2021

Insurances Accepted for vaccination

**Copy of insurance card preferred (front and back) if copy of insurance card is not available, complete all information below.*

Private Insurance Provider: (circle one)

- 1) Blue Cross/Blue Shield 2) Cigna 3) Humana 4) United Health Care 5) Cover Kids

****Only Insurances listed will be accepted***

TennCare Insurance Provider: (circle one)

- 1) BlueCare 2) Amerigroup 3) United Healthcare Community Plan

Member Subscriber Name as on card: _____ **Group #** _____

Member / Subscriber ID: _____

Address to send medical claims to: *(information typically found on the back of the card)*

For questions or concerns, please call: (423) 279-2777

Area below for official use ONLY

#1 **Manufacturer: Sanofi**

VIS Date: _____

Other _____

Lot number: _____

Site administered: Right Deltoid

Left Deltoid

Intranasal

Date Given: _____

Signature: _____

Signature Above indicates immunization given according to PHN Protocol

Over