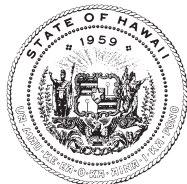


DAVID Y. IGE  
GOVERNOR OF HAWAII



VIRGINIA PRESSLER, M.D.  
DIRECTOR OF HEALTH

STATE OF HAWAII  
DEPARTMENT OF HEALTH  
P. O. BOX 3378  
HONOLULU, HI 96801-3378

In reply, please refer to:  
File:

**ATTENTION: This packet is available on-line, including fillable, electronic versions of the vaccination Consent Forms. If you would prefer the on-line version, visit our website at: <https://vaxonlinereg.doh.hawaii.gov>**

August 2015

Dear Parents/Guardians:

The 9<sup>th</sup> year of the Hawaii State Department of Health free school-located flu vaccination program (Stop Flu at School) for students in K-8<sup>th</sup> grades will begin this fall, in partnership with the Department of Education, the Hawaii Association of Independent Schools, and the Hawaii Catholic Schools. Both the shot and the nasal spray forms of the flu vaccine will be offered, and information about both (Vaccine Information Statements) is enclosed. Please read these statements to help you decide which vaccine type would be best for your child.

Vaccines will be administered at your child's school between October and November 2015. Your school will notify you of the specific date and time. If you would like your child to receive a free flu vaccine at school:

1. Choose the type of vaccine you want your child to receive:  
**Nasal Spray** (Live, Intranasal Influenza Vaccine)  
OR  
**Shot** (Inactivated Influenza Vaccine)
2. Complete *either* an online version of the Consent Form or the attached paper copy. Please complete **ONLY ONE** Consent Form for your child.  
**Online:** Visit the following website for detailed instructions: <https://vaxonlinereg.doh.hawaii.gov>  
**Paper copy:**  
Nasal Spray – **YELLOW** Consent Form  
OR  
Shot – **GREEN** Consent Form
3. Complete requested information on Consent Form
4. **ALL** of the questions **MUST** be answered
5. **PRINT** (on-line Consent Form only), **SIGN, AND DATE** the consent form
6. **Return the completed Vaccination Consent Form to your child's teacher by September 4, 2015.**
7. Do not return a completed Consent Form if you do not want your child to be vaccinated at school.

There will be only one clinic per school. If your child needs a 2<sup>nd</sup> dose of flu vaccine (children aged 8 years and younger, who are receiving the flu vaccine for the first time), please schedule an appointment with your child's doctor for the 2<sup>nd</sup> dose.

If you submit a consent form to the school and your child receives a flu vaccine at his/her doctor's office **before** the scheduled school vaccination clinic, you **must** pick up your child's consent form at the school before the scheduled clinic date to be sure that your child is not unnecessarily vaccinated again.

For additional information about the Stop Flu at School program, visit <http://flu.hawaii.gov/SFAS.html> or call 2-1-1, Monday through Friday, 7:00 a.m. - 5:00 p.m.

Sincerely,

Sarah Y. Park, M.D., F.A.A.P.  
State Epidemiologist

Enclosures



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The main body of the page is a large, empty rectangular area, bounded by a solid line on the left and right sides and a dashed line at the top. This area is intended for writing or drawing.

# STUDENT Vaccination Consent Form - **FLU NASAL SPRAY**

(PLEASE PRINT LEGIBLY IN CAPITAL LETTERS USING BLACK OR BLUE INK)

<b>STUDENT'S LAST NAME</b>	<b>STUDENT'S FIRST NAME</b>	<b>MI(S)</b>	<b>STUDENT'S DATE OF BIRTH</b> M M / D D / Y Y		
<b>STUDENT'S ADDRESS</b>					
			( ) -		
<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	<b>HOME PHONE NUMBER</b>		

**STUDENT IS A:**  
 TWIN  TRIPLET

**STUDENT'S GENDER:**  
 MALE  FEMALE

<b>PARENT/GUARDIAN'S NAME (LAST)</b>	<b>(FIRST)</b>	<b>DAYTIME PHONE</b>	<b>CELL PHONE</b>
<b>SCHOOL NAME</b>		<b>GRADE (SELECT ONE "●")</b>	
		<input type="radio"/> JrK <input type="radio"/> K <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 <input type="radio"/> 11 <input type="radio"/> 12 JRK K 1 2 3 4 5 6 7 8 9 10 11 12	
<b>HOMEROOM TEACHER'S NAME (LAST, FIRST)</b>			
<b>STUDENT'S DOCTOR'S NAME (LAST)</b>		<b>(FIRST)</b>	
<b>STUDENT'S HEALTH INSURANCE: (SELECT ONE "●")</b> The Stop Flu at School program is <b>FREE</b> . Your insurance company will NOT be billed.			
<input type="radio"/> HMSA – PRIVATE <input type="radio"/> KAISER – PRIVATE <input type="radio"/> UNITEDHEALTHCARE – PRIVATE <input type="radio"/> ALOHACARE <input type="radio"/> UHA <input type="radio"/> HMA <input type="radio"/> OHANA <input type="radio"/> HMSA – QUEST <input type="radio"/> KAISER – QUEST <input type="radio"/> UNITEDHEALTHCARE – QUEST <input type="radio"/> CHAMPUS/TRICARE <input type="radio"/> MDX <input type="radio"/> HMAA <input type="radio"/> OTHER <input type="radio"/> NO INSURANCE			
<b>INSURANCE POLICY NUMBER</b>			

The following questions will help us to determine if your child may receive the **FLU NASAL SPRAY** (live, attenuated intranasal influenza vaccine). Please select **YES** or **NO** ("●") for each question.

	YES	NO
1. Has your child ever had a serious allergic reaction to eggs or to a component of any flu vaccine?	<input type="radio"/>	<input type="radio"/>
2. Has your child ever had a serious reaction to a previous dose of flu vaccine?	<input type="radio"/>	<input type="radio"/>
3. Has your child ever had Guillain-Barré Syndrome (a serious nervous system disorder)?	<input type="radio"/>	<input type="radio"/>
4A. Has your child ever had <b>WHEEZING or ASTHMA</b> ?	<input type="radio"/>	<input type="radio"/>
B. Does your child have a long-term health problem such as heart disease, kidney disease, lung disease, cognitive, neurologic or neuromuscular disease, liver disease, metabolic disease such as diabetes, or blood disorders such as anemia?	<input type="radio"/>	<input type="radio"/>
5. Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, has he/she taken medications that weaken the immune system, such as cortisone, prednisone, other steroids or anticancer drugs; or has he/she had radiation treatments?	<input type="radio"/>	<input type="radio"/>
6. Does your child live with or expect to have close contact with anyone with a severely weakened immune system requiring care in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	<input type="radio"/>	<input type="radio"/>
7. Is your child receiving aspirin therapy or other aspirin-containing medication?	<input type="radio"/>	<input type="radio"/>
8. Is your child taking any prescription medicines to prevent or treat flu (i.e., Tamiflu® or Relenza®)?	<input type="radio"/>	<input type="radio"/>

**If you answered YES to any question, left any question blank, or you are unsure of the answer to any of the questions above, your child will not receive the Flu Nasal Spray through the school vaccination program, but may be able to receive a Flu Shot (see GREEN Flu Shot Consent Form).**

**CONSENT FOR CHILD'S VACCINATION:** I have received and read the 2015-16 Vaccine Information Statement for Flu Vaccine, Live, Intranasal. The **FLU NASAL SPRAY** should not be given within 4 weeks of a live virus vaccine (e.g., MMR, MMRV, varicella), so I will inform my child's doctor that my child will be receiving a **FLU NASAL SPRAY** vaccine at school between October – November 2015. I understand the risks and benefits, and give consent to the State of Hawaii Department of Health and its authorized staff for my child, named at the top of this form, to receive the **FLU NASAL SPRAY** and to share information regarding my child's influenza vaccination with my child's doctor and my child's health insurance company. I agree to waive and release any claims against the State, all contributory members of the Hawaii Association of Health Plans, and all other program sponsors, related to or arising from the Stop Flu at School Program. In addition, I have received information regarding the Hawaii Immunization Registry (see reverse side).

Signature/Parent or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

FOR ADMINISTRATIVE USE ONLY								
Vaccine	Date Dose Administered	Dose Size	Route	Vaccine Manufacturer	Lot Number	Expiration Date	VIS Publ. Date	Name, Address, & Title of Vaccine Administrator
Live, intranasal influenza vaccine	/ /	0.2 ml	Intranasal	MedImmune		/ /	/ /	

Reason **FLU NASAL SPRAY NOT** given:  
  Student had temperature of 100.5° or higher  
  Student refused **FLU NASAL SPRAY**  
 Student's consent form incomplete  
  Student absent  
 Other: \_\_\_\_\_



## HAWAII IMMUNIZATION REGISTRY INFORMATION

### INFORMATION CONTAINED IN THE REGISTRY

- Immunization information including but not limited to vaccine type, date of vaccine administration, vaccine administration site and route, lot number, expiration date, patient's history of vaccine preventable diseases, contraindications, precautions, adverse reactions, and/or comments regarding vaccinations.
- Personal information including but not limited to an individual's first, middle, and last name, date of birth, gender, mailing address, phone number, parent/guardian name, parent/guardian relationship to the individual, their contact information, and mother's maiden name.

### CONFIDENTIALITY AND PRIVACY INFORMATION

All authorized users and the Department of Health Immunization Branch acknowledge that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (PL 104-191 and 45 CFR Parts 160 and 164, "Standards for Privacy of Individually Identifiable Health Information") governs the use and disclosure of individually identifiable information by entities subject to the Privacy Rule. Although HIPAA standards for privacy were used as a guide to assist in the development of the Registry Confidentiality and Privacy policies, the Registry and the Department of Health Immunization Branch are not "covered entities" under HIPAA. Providers, health plans and other covered entities who are authorized users must comply with the HIPAA Privacy Rule.

Registry information will be entered by and available to authorized users for authorized purposes only. All authorized users will be required to safeguard the privacy of patient participants by protecting confidential information in the Registry in accordance with the Hawaii Immunization Registry Confidentiality and Privacy Policy, the Hawaii Immunization Registry Security Policy, as well as all applicable State and Federal Laws.

### AUTHORIZED USERS

Authorized users of the Registry may include individuals and/or entities that require regular access to patient immunization and other individually identifiable health information to provide immunization services to specific patients, maintain a computerized inventory of their public and private stock of vaccines, assess immunization status to determine immunization rates, and/or ensure compliance with mandatory immunization requirements. All authorized users are required to sign a Hawaii Immunization Registry Confidentiality and Security Statement indicating that they have received a copy of the Hawaii Immunization Registry Confidentiality and Privacy Policy and the Hawaii Immunization Registry Security Policy, understand the terms, including penalties for violation of the policies, and agree to comply with the policies.

The Department of Health Immunization Branch is responsible for oversight of the Registry and therefore will be designated as an authorized user.

### USES OF REGISTRY INFORMATION (AUTHORIZED PURPOSES)

Registry immunization data and other individually identifiable health information shall be utilized by authorized users for the purposes of:

- Consolidating, maintaining, and accessing computerized immunization records;
- Consolidating and maintaining vaccine inventory information;
- Determining the immunization history of individuals and delivering health care treatment accordingly;
- Generating notices for individuals who are due or overdue for immunizations and in the event of a vaccine recall;
- Staying abreast of the complex immunization schedule by utilizing registry-supplied immunization forecasting tools;
- Assessing the immunization rate of their patient population (or subsets thereof);
- Generating official immunization records (e.g. Student's Health Record);
- Ensuring compliance with mandatory immunization requirements;
- Recording the distribution of prophylactic and treatment medications administered or dispensed in preparation for and in response to a potentially catastrophic disease threat;
- Complying with Hawaii Vaccines For Children and other State-provided vaccine programs' vaccine ordering and accountability policies and procedures; and
- Other purposes determined at the discretion of the Department of Health Immunization Branch.

Registry immunization data and other individually identifiable health information shall be utilized by the Department of Health Immunization Branch for the following public health purposes including but not limited to:

- Ensuring compliance with mandatory immunization requirements;
- Performing Quality Improvement/Quality Assessment activities;
- Complying with Hawaii Vaccines For Children and other State-provided vaccine programs' vaccine ordering and accountability policies and procedures;
- Preventing and managing outbreaks of vaccine-preventable diseases and other public health emergencies;
- Producing immunization assessment reports to aid in the development of policies and strategies to improve public health;
- Managing and maintaining the Registry system; and
- Other purposes determined at the discretion of the Department of Health Immunization Branch.

### AVAILABILITY OF IMMUNIZATION RECORD INFORMATION

An individual's immunization data and other individually identifiable health information in the Registry will be made available to the individual's immunization provider, the Department of Health, and other Registry authorized users for authorized purposes only.

### OPT-OUT

Individuals may choose not to include their or their child's immunization data in the Registry ("opt-out"). Individuals must opt-out in writing by completing a "Hawaii Immunization Registry Opt-Out Form" which is available from the individual's immunization provider or the Department of Health Immunization Branch. The Registry will retain only core demographic information necessary to identify the individual has chosen to opt-out of the Registry. This information is necessary to enable the Registry to filter and refuse entry of immunization information for the individual. Core demographic data will be for Hawaii Department of Health use only and will be non-displaying to all other Registry authorized users. An individual's decision not to authorize the inclusion of immunization data in the Registry will not affect whether or not they receive immunizations.

### REVOCACTION

An individual may revoke their decision to opt-out of the Hawaii Immunization Registry at any time. Revocations must be made in writing by completing a "Hawaii Immunization Registry Reauthorization Form" obtained from the individual's immunization provider or the Department of Health Immunization Branch.

### RIGHT TO INSPECT, COPY, CORRECT OR AMEND PERSONAL AND IMMUNIZATION INFORMATION

Individuals may inspect, copy, correct or amend their or their child's immunization record information via their or their child's immunization provider. For information on how to inspect, copy, correct or amend your or your child's information, please speak with your doctor.

### QUESTIONS?

If you have any questions about the Registry, please speak with your doctor or visit our website at: <http://health.hawaii.gov/docd/hawaii-immunization-registry/>.

# STUDENT Vaccination Consent Form - **FLU SHOT**

(PLEASE PRINT LEGIBLY IN CAPITAL LETTERS USING BLACK OR BLUE INK)

<b>STUDENT'S LAST NAME</b>	<b>STUDENT'S FIRST NAME</b>	<b>MI(S)</b>	<b>STUDENT'S DATE OF BIRTH</b> M M / D D / Y Y		
<b>STUDENT'S ADDRESS</b>					
<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	<b>HOME PHONE NUMBER</b> (    )    -		

<b>PARENT/GUARDIAN'S NAME (LAST)</b>	<b>(FIRST)</b>	<b>DAYTIME PHONE</b>	<b>CELL PHONE</b>
<b>SCHOOL NAME</b>		<b>GRADE (SELECT ONE "●")</b>	
<b>HOMEROOM TEACHER'S NAME (LAST, FIRST)</b>		<input type="radio"/> JRK <input type="radio"/> K <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 <input type="radio"/> 11 <input type="radio"/> 12 <b>JRK K 1 2 3 4 5 6 7 8 9 10 11 12</b>	
<b>STUDENT'S DOCTOR'S NAME (LAST)</b>		<b>(FIRST)</b>	
<b>STUDENT'S HEALTH INSURANCE:</b> (SELECT ONE "●") The Stop Flu at School program is <b>FREE</b> . Your insurance company will NOT be billed.			
<input type="radio"/> HMSA – PRIVATE <input type="radio"/> KAISER – PRIVATE <input type="radio"/> UNITEDHEALTHCARE – PRIVATE <input type="radio"/> ALOHACARE <input type="radio"/> UHA <input type="radio"/> HMA <input type="radio"/> OHANA <input type="radio"/> HMSA – QUEST <input type="radio"/> KAISER – QUEST <input type="radio"/> UNITEDHEALTHCARE – QUEST <input type="radio"/> CHAMPUS/TRICARE <input type="radio"/> MDX <input type="radio"/> HMAA <input type="radio"/> OTHER <input type="radio"/> NO INSURANCE			
<b>INSURANCE POLICY NUMBER</b>			

- The following questions will help us to determine if your child may receive the **Flu Shot** (inactivated influenza vaccine). Please select **YES** or **NO** ("●") for each question.
- |  |                       |                       |
|--|-----------------------|-----------------------|
|  | <b>YES</b>            | <b>NO</b>             |
| 1. Has your child ever had a serious allergic reaction to eggs or to a component of any flu vaccine? | <input type="radio"/> | <input type="radio"/> |
| 2. Has your child ever had a serious reaction to a previous dose of flu vaccine?                     | <input type="radio"/> | <input type="radio"/> |
| 3. Has your child ever had Guillain-Barré Syndrome (a serious nervous system disorder)?              | <input type="radio"/> | <input type="radio"/> |

**If you answered YES to any question, left any question blank, or you are unsure of the answer to any of the questions above, your child will NOT receive the Flu Shot (inactivated influenza vaccine) through the school vaccination program. Please talk to your child's doctor.**

**CONSENT FOR CHILD'S VACCINATION:** I have received and read the 2015-16 Vaccine Information Statement for Flu Vaccine, Inactivated. I understand the risks and benefits, and give consent to the State of Hawaii Department of Health and its authorized staff for my child, named at the top of this form, to receive the **FLU SHOT** and to share information regarding my child's influenza vaccination with my child's doctor and my child's health insurance company. I agree to waive and release any claims against the State, all contributory members of the Hawaii Association of Health Plans, and all other program sponsors, related to or arising from the Stop Flu at School Program. In addition, I have received information regarding the Hawaii Immunization Registry (see reverse side).

Signature/Parent or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

FOR ADMINISTRATIVE USE ONLY									
Vaccine	Date Dose Administered	Dose Size	Site	Route	Vaccine Manufacturer	Lot Number	Expiration Date	VIS Publ. Date	Name, Address, & Title of Vaccine Administrator
Inactivated influenza vaccine	/ /	0.5 ml	RA LA	IM			/ /	/ /	

- Reason **FLU SHOT NOT** given:
- Student had temperature of 100.5° or higher
  - Student's consent form incomplete
  - Student refused **FLU SHOT**
  - Student absent
  - Other: \_\_\_\_\_

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- Assessing the immunization rate of their patient population (or subsets thereof);
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- Preventing and managing outbreaks of vaccine-preventable diseases and other public health emergencies;
- Producing immunization assessment reports to aid in the development of policies and strategies to improve public health;
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### QUESTIONS?

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