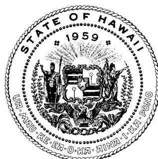
LINDA LINGLE
GOVERNOR OF HAWAII



CHIYOME LEINAALA FUKINO, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O Box 3378
Honolulu, Hawaii 96801-3378

August 2, 2010

Dear Parents:

The 4th year of the Hawaii State Department of Health free school-located flu vaccination program (Stop Flu at School) for students in K-8th 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 as usual, 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 December 2010. 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 **ONLY ONE** Consent Form:
   Nasal Spray – **YELLOW** Consent Form
   OR
   Shot – **GREEN** Consent Form
   a) Complete requested information
   b) **ALL** of the questions **MUST** be answered
   c) **SIGN AND DATE** the consent form
3. **Return the completed Vaccination Consent Form to your child's teacher by September 9, 2010.**
4. Do not return the Consent Form if you do not wish your child to be vaccinated at school.

There will be only one clinic per school. If your child needs a 2nd 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 2nd 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 vaccinated.

If you have any questions regarding this school flu vaccination program, please call Aloha United Way 2-1-1, Monday through Friday, 6:00 a.m. – 9:00 p.m.

Sincerely,

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

Enclosure

Frequently Asked Questions

My child is healthy - does my child need a flu vaccine?
Yes. The Advisory Committee on Immunization Practices recommends yearly flu vaccination for **ALL** children aged 6 months through 18 years. This recommendation should reduce the risk of flu among children, their need for doctors' visits, and missed time from school. Also, decreasing the spread of flu among children may reduce flu among their household members and within the community.

When will the flu vaccine be given?
School-based flu vaccinations will begin in October 2010. Each participating school will have its own clinic date and time. Your child's school will notify you of the specific clinic date.

Last year, DOH held a second clinic at participating schools for the 2009 H1N1 flu vaccine. Will DOH be holding H1N1 clinics again in 2010-2011?
For the 2010-2011 flu season, the regular seasonal flu vaccine will contain a 2009 H1N1-like component, so there will not be a need for a separate 2009 H1N1 vaccination clinic.

What do I have to do for my child to get the flu vaccine at school?
Participating is easy! Just read the Vaccine Information Statements, choose the type of flu vaccine (Nasal Spray or Shot) that you want your child to receive, and complete, sign, and return the appropriate consent form (**YELLOW** – Flu Nasal Spray; **GREEN** – Flu Shot) to your child's school.

What if my child receives a flu vaccine at the doctor's office after I send in his/her Consent Form?
You will need to pick up your child's Consent Form from the school before the scheduled school vaccination clinic date to make sure that your child is not vaccinated.

Does the flu vaccine contain thimerosal?
Some brands do. Most inactivated flu vaccines (injectable vaccines or "flu shots") currently contain only a small amount of thimerosal as a preservative. The nasal spray flu vaccine does not contain thimerosal.

Is it safe for children to receive a flu vaccine that contains thimerosal?
There is no scientific evidence of harm caused by the small amount of thimerosal in vaccines. The following websites provide additional information: US Food & Drug Administration (http://www.fda.gov/cber/vaccine/thimerosal.htm#t1) or the Centers for Disease Control & Prevention (http://www.cdc.gov/vaccinesafety/Concerns/thimerosal/index.html).

For additional information about the school flu vaccination program, visit www.stopfluatschool.com or call Aloha United Way 2-1-1, Mon – Fri, 6 a.m. – 9 p.m.

☑ PLEASE REMEMBER TO:

- ☐ Choose which flu vaccine type you wish your child to receive
- ☐ Complete only **ONE** Consent Form (**YELLOW** – Flu Nasal Spray; **GREEN** – Flu Shot)
- ☐ Answer all of the questions
- ☐ Sign and date the Consent Form
- ☐ Return the consent form to your child's school by **September 9, 2010**.

STUDENT Vaccination Consent Form - FLU NASAL SPRAY

(PLEASE PRINT IN BLACK OR BLUE INK)

STUDENT'S NAME (Last)	(First)	(M.I.)	STUDENT Date of Birth / /	AGE (YEARS)
PARENT/GUARDIAN'S NAME (Last)	(First)	(M.I.)	STUDENT'S GENDER (Select one "●") Ⓜ MALE Ⓕ FEMALE	

ADDRESS

DAYTIME PHONE:
HOME PHONE:
CELL:

CITY | **ZIP** | **EMAIL ADDRESS**

SCHOOL NAME

HOMEROOM TEACHER'S NAME (Last, First)

GRADE (Select one "●")

JrK K 1 2 3 4 5 6 7 8 9 10 11 12

STUDENT'S DOCTOR'S NAME (Last, First) Address City Zip

STUDENT'S HEALTH INSURANCE: (Select one "●") The Stop Flu at School program is **FREE**. Your insurance company will NOT be billed.

○ HMSA – Private ○ KAISER – Private ○ AlohaCare ○ UHA ○ CHAMPUS/TRICARE ○ No insurance
○ HMSA – Med-Quest ○ KAISER -Med-Quest ○ HMAA ○ Summerlin ○ Other:_____________ ○ Not sure

INSURANCE POLICY NUMBER:

LAST 4 DIGITS of STUDENT'S SSN ____ ____ ____ ____

The following questions will help us to determine if your child may receive the **FLU NASAL SPRAY** (live, 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?	○	○
2.	Has your child ever had a serious reaction to a previous dose of flu vaccine?	○	○
3.	Has your child ever had Guillain-Barré Syndrome (a serious nervous system disorder)?	○	○
4A.	Has your child ever had **WHEEZING or ASTHMA**?	○	○
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?	○	○
5.	Does your child have a weakened immune system caused by cancer, cancer treatment such as radiation or drugs, HIV/AIDS, or other disorder; is your child taking other drugs such as steroids that weaken the immune system?	○	○
6.	Does your child live with or have close contact with anyone with a severely weakened immune system requiring care in a protected environment?	○	○
7.	Is your child receiving aspirin or other aspirin-containing medication?	○	○
8.	Is your child taking any prescription medicines to prevent or treat flu (i.e. Tamiflu® or Relenza®)?	○	○

If you answered YES, left any blank, or you are unsure of the answer to any of the above questions, 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 2010-11 Vaccine Information Statement for Live, Intranasal Influenza Vaccine. The **FLU NASAL SPRAY** should not be given within 4 weeks of a MMR (measles/mumps/rubella) or varicella (chickenpox) vaccine, so I will inform my child's doctor that my child will be receiving a **FLU NASAL SPRAY** vaccine at school between October – December 2010. 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. 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 Department of Health
May 12, 2010

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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 and expiration date.
- 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; 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/Teen Vax Program vaccine 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; 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 and other individually identifiable health information 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 Department of Health Immunization Branch. An individual's decision not to authorize the inclusion of immunization data and other individually identifiable information in the Registry will not affect whether or not they receive immunizations.

REVOCATION

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 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 the Department of Health Immunization Branch. For information on how to inspect, copy, correct or amend your or your child's information, please call the Department of Health Immunization Branch at 586-4665 (Oahu) or 1-888-447-1023 (neighbor islands), or e-mail your request to RegistryHelp@doh.hawaii.gov.

QUESTIONS?

If you have any questions about the Registry, please call the Department of Health Immunization Branch at 586-4665 (Oahu) or 1-888-447-1023 (neighbor islands), e-mail your question to RegistryHelp@doh.hawaii.gov, or visit our website at: http://hawaii.gov/health/family-child-health/immunization/registry/index.html.

STUDENT Vaccination Consent Form - FLU SHOT

(PLEASE PRINT IN BLACK OR BLUE INK)

STUDENT'S NAME (Last)	(First)	(M.I.)	STUDENT Date of Birth / /	AGE (YEARS)
PARENT/GUARDIAN'S NAME (Last)	(First)	(M.I.)	STUDENT'S GENDER (Select one " ● ") Ⓜ MALE Ⓕ FEMALE	

ADDRESS		DAYTIME PHONE: HOME PHONE: CELL:
CITY	ZIP	EMAIL ADDRESS

SCHOOL NAME	GRADE (Select one " ● ")
HOMEROOM TEACHER'S NAME (Last, First)	Ⓙ JrK Ⓚ K ① 1 ② 2 ③ 3 ④ 4 ⑤ 5 ⑥ 6 ⑦ 7 ⑧ 8 ⑨ 9 ⑩ 10 ⑪ 11 ⑫ 12

STUDENT'S DOCTOR'S NAME (Last, First) Address City Zip

STUDENT'S HEALTH INSURANCE: (Select one "●") The Stop Flu at School program is FREE. Your insurance company will NOT be billed.

○ HMSA – Private ○ KAISER – Private ○ AlohaCare ○ UHA ○ CHAMPUS/TRICARE ○ No insurance
○ HMSA – Med-Quest ○ KAISER -Med-Quest ○ HMAA ○ Summerlin ○ Other:_____________ ○ Not sure

INSURANCE POLICY NUMBER:	LAST 4 DIGITS of STUDENT'S SSN ____ ____ ____ ____

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.

	YES	NO
1. Has your child ever had a serious allergic reaction to eggs or to a component of any flu vaccine?	○	○
2. Has your child ever had a serious reaction to a previous dose of flu vaccine?	○	○
3. Has your child ever had Guillain-Barré Syndrome (a serious nervous system disorder)?	○	○

If you answered YES to any questions, left any questions blank, or you are unsure of the answer to any of the above questions, 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 2010-11 Vaccine Information Statement for Inactivated Influenza Vaccine. 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. 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 100.5º or higher
○ Student's consent form incomplete
○ Student refused **FLU SHOT**
○ Student absent
○ Other: ______________________

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