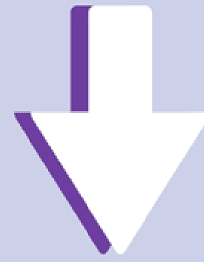
Coos Bay Schools Vaccine Clinic

In Memory Of Blake Crane

Free Flu shots for staff and students provided by the Waterfall Community Health Center in coordination with the Coos Bay School District.

Vaccinations will be administered, to those with completed consent forms, by the Waterfall Community Health Center staff in their Mobile Health Bus at the school your student attends. We will maintain social distancing and school COVID policies.

Please complete the attached consent form if you wish to receive a flu shot. You may bring your consent form and attend anytime during your school's clinic, or schedule an appointment with your school nurse. You may also turn in the consent form for your child and we will ensure they receive their vaccine on the clinic day.



Among healthy children, flu vaccination reduces risk of death from influenza by

65%

Open to all Staff and Students

MHS
October 21st; 9:00-12:00

Madison/Sunset
October 24th; 9:00-3:00

Destinations(Blossom)/**MJH**
October 25th; 9:00-12:00(MHS)
1:00-3:00(MJH)

Eastside/Millicoma
October 27th; 9:00-3:00

GET YOUR FLU SHOT
IN HONOR OF BLAKE CRANE

who left us too soon after suffering serious complications of the Flu.
Blake was 1 out of 188 pediatric flu deaths in the U.S. during the 2019-20 flu season.

MHS CLASS 2021

In memory of Blake, never be afraid to be yourself.
BE YOU. BE UNIQUE.

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at www.fda.gov/vaccines-blood-biologics/vaccines.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at www.cdc.gov/flu.

Parent/Guardian Consent for Flu Immunization at School:

I have read/had explained to me the current year's Vaccine Information Statement (VIS) with information about influenza and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to my child. I agree that neither the School, School Districts nor their sponsor shall have any responsibility or liability if I contract influenza, or other respiratory diseases, or suffer any other adverse reaction following administration of the flu shot. I understand that the vaccine will be provided free of charge.

Signature ______________________________**Printed Name**_____________________ **Date:** _________

Relationship to the student________________________________ **School**________________________

(legal guardian must sign if student is under 15 years old)

Vaccine Administration Record

Waterfall Community Health Center
1890 Waite Street, Suite 1
North Bend, Oregon 97459
Write or stamp clinic address here

Patient Information

Last Name: ____________________ First Name: ______________ Middle Name: ___________

Date of Birth: ______________ Age: ___ years: ___ months (if under age 5) Gender: Male ___ Female ___

Address: ____

Mailing Address: ____

Phone Number: _______________ Mother's Maiden Name (optional): ____________________

Race: (Circle all that apply) American Indian/Alaskan Native Asian White Decline to Answer African American Native Hawaiian/Pacific Islander

Ethnicity: Hispanic? Yes ___ No ___ Decline _______ Primary Language: _______________

Social Security Number (optional): ______ — ____ — _______ Medicaid ID Number (optional): ________

☐ I have received this clinic's HIPAA Notice of Privacy Practices

Patient Screening Questions	Circle one:	
Does the patient have a fever or feel sick today?	Yes	No
Does the patient have allergies to medicines, food, latex or vaccines?	Yes	No
Has the patient had a bad reaction to a vaccination?	Yes	No
Has the patient had a seizure or a brain problem?	Yes	No
Does the patient have cancer, leukemia, AIDS or other immune system problem?	Yes	No
Does the patient have heart disease, lung disease, kidney disease, diabetes, asthma, anemia or other long term condition?	Yes	No
Has the patient taken cortisone, prednisone, other steroids or cancer treatments in the last 3 months?	Yes	No
Has the patient received blood, blood products or immune globulin (IG) in the past year?	Yes	No
Is the patient pregnant or planning to become pregnant?	Yes	No
Has the patient received vaccines in the past month?	Yes	No
Has the patient ever fainted after injections?	Yes	No
Has the patient had chicken pox?	Yes	No
If yes, when (estimated date):		

I have received the Vaccine Information Statement(s) for the vaccines to be given and I have had all of my questions answered. I request that the vaccine be given to me or to the person named above, for whom I am responsible. I allow the release of any information needed to process insurance claims and request payments of medical benefits.

Print name: ________________________________

Signature: ________________________________

Relationship to patient: ________________________

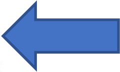
Date: ________________________________

Bring this page with name filled in, then leave blank for clinic use

Clinic enter MRN:________________

Vaccine Administration Record
FOR CLINIC USE ONLY

Patient Name: ______________________________



☐ One Time Only

Dose #	Vaccine	Brand Name	Lot Number	Exp.	Manuf.	Dose (ML)	Site/Rte	Elig.	VIS Pub Date	Date VIS Given
	DTaP	Infanrix Tripedia Daptacel			GSK Sanofi Sanofi	0.5				
	DTaP/Hep.B/IPV	Pediarix			GSK	0.5				
	DTaP/Hib/IPV	Pentacel			Sanofi	0.5				
	DTaP/IPV	Kinrix			GSK	0.5				
	Hep. A	Vaqta (peds/adult) Havrix (peds/adult)			Merck GSK	0.5 1.0				
	Hep. A – Hep. B	Twinrix			GSK	1.0				
	Hep. B	Recomb. (peds/adult) Engerix (peds/adult)			Merck GSK	0.5 1.0				
	Hib	ActHib Hiberix PedVax			Sanofi GSK Merck	0.5				
	Hib-Hep. B	Comvax			Merck	0.5				
	HPV	Gardasil Cervarix			Merck GSK	0.5				
	Influenza live	Flumist (3 or 4)			MedImm	0.2				
	Influenza split					0.25 0.5				
	IPV	IPOL			Sanofi	0.5				
	MCV4	Menactra Menveo			Sanofi Novartis	0.5				
	MCV2	MenHibrix			GSK	0.5				
	MPSV4	Menomune			Sanofi	0.5				
	MMR	MMR II			Merck	0.5				
	MMRV	ProQuad			Merck	0.5				
	PCV13	Prevnar 13			Wyeth	0.5				
	PPV23	Pneumovax			Merck	0.5				
	Rotavirus	Rotarix RotaTeq			GSK Merck	1.0 2.0				
	Tdap	Boostrix Adacel			GSK Sanofi	0.5				
	Td	Decavac Tenivac			Sanofi	0.5				
	Varicella	Varivax			Merck	0.5				
	Zoster	Zostavax			Merck	0.65				
	Other									

PPD Test	Reason Given Code	Lot # and Manufacturer	Inject. Code	MM Results	Date Read	Time Read	Read By

Vaccine Administrator Signature:______________________ Title:________________ Date: ______________

Vaccine Administrator Signature*:______________________ Title:________________ Date: ______________
*Use this 2nd signature line if more than one person gave immunizations to client.