



Diller-Odell

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Public Health
Solutions

District Health Department

Serving Fillmore, Gage, Jefferson, Saline, and Thayer counties.

The SKIP Flu immunization clinic will be offered at your child's school on **October 22, 2024.**

It is more important than ever to remain as healthy as possible. Increasing the amount of people who are immunized will help to reduce the spread of the flu. We realize that the flu shot does not guarantee to protect 100% against getting the flu, but it will greatly reduce the length and severity of symptoms should you get the flu and protect your family and friends.

To have your child vaccinated, please do the following:

1. **Complete and Sign the Permission Form.**
You must complete the attached Permission Form/Forms and answer all the Screening Questions. Return the completed form to your child's school. **Children without a completed and signed consent form will not be immunized. All questions must be answered.**
2. **Insured? - - Just include a copy of your insurance or Medicaid/Medicaid Managed Care Cards**
Please include a photocopy (FRONT AND BACK ON FULL SHEET OF PAPER) of your insurance or Medicaid/Medicaid Managed Care card. There will be **no cost to your family** as we bill the insurance company.
3. **Are you uninsured?**
Mark the uninsured box on the Permission Form. There will be **no charge** for the vaccination thanks to the support from the county boards and from federal vaccine funding.
4. **Show these Viruses who is the Winner!**
Every student who turned in their Consent Form and got the flu shot the day of the clinic will be entered into a drawing for a \$20.00 gift card.

Children under the age of nine who have never had the flu vaccine before, or did not receive two doses prior to this year, will need a second dose (booster). Our nurses will review your child's record and will let you know if a booster is needed.

If you need a flu shot, or know someone who needs one, and are unsure where to go, please call us! **Remember—your flu shot protects both you and those you love!** Questions? Call Public Health Solutions District Health Department at 402-826-3880 or toll-free 1-844-830-0813.

This program is supported by Public Health Solutions Board of Health and County Commissioner / Supervisor Boards which help provide funding for anyone who is uninsured.

Sincerely,

Kimberly Showalter
Health Director



Public Health
Solutions

Public Health Solutions Influenza Vaccine Screening/Permission Form 2024-2025

The questions below will be used to decide if you or your child should get *inactivated injectable influenza vaccine*. Answering "yes" to any question does not mean you or your child cannot get flu vaccine today. It means more questions will be asked.

Name: _____ Date of Birth: _____ Sex: Female Male

Address: _____ City/State/Zip: _____

Phone: _____ School: _____

Insurance (ATTACH A COPY) Medicaid/Managed Care (ATTACH A COPY) No Insurance

SCREENING QUESTIONS: Adult/Parent/Guardian: Please answer **ALL** the questions below with **YES** or **NO**. If this form is not completed, signed and returned to school on or before the date of the clinic, vaccine **WILL NOT** be given.

- 1. Is the person getting vaccine sick today? Yes / No
- 2. Does the person getting vaccine have an allergy to any flu vaccine ingredient? Yes / No
- 3. Has the person getting vaccinated ever had a serious reaction to a flu vaccine? Yes / No
- 4. Has the person getting vaccine ever had Guillain Barré syndrome? Yes / No

Permission

- I have been given a copy of the 2024-2025 Influenza Vaccine information Statement (VIS), and I have read and/or had the information on inactivated influenza vaccine read to me.
- I have had the chance to ask questions and had those questions answered in a way I can understand.
- I understand the risks and benefits of getting the vaccine and I ask that the influenza vaccine be given to me or the person named above for whom I can legally give permission.
- I understand and agree that Public Health Solutions and the school are not responsible for any unexpected reactions that may happen.
- I understand and agree that it is my responsibility to get medical attention for myself or my child if an unexpected or allergic reaction happens.

Signature: _____ Date: _____

Patient/Parent/Guardian

OFFICE USE ONLY

Nurse Signature: _____

Please attach vaccine information sticker and sign form.