



November 11, 2009

Dear Parents/Guardians:

As you know, a new influenza virus, called the 2009 H1N1 influenza virus, was first identified in the United States in late April 2009. The Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices has recommended that children and young adults aged 6 months through 24 years be vaccinated against 2009 H1N1 as soon as the vaccine is available.

The Louisville Metro Department of Public Health and Wellness (LMDPHW) and the Archdiocese of Louisville are working with your child's school to give the 2009 H1N1 influenza vaccine to children at Catholic schools. We will hold vaccination clinics beginning in late November and continuing through mid-December. Your child's school will communicate specific dates to you.

Permission forms and vaccine information sheets are attached to this letter. There will be no cost to you for this vaccine. **Permission forms must be completely filled out and submitted to your child's school before a vaccine will be administered. If the form is not completely filled out and signed to give permission, your child will not receive the vaccine. The permission form also allows you to refuse the vaccination for your child. If you refuse, the vaccination will not be given to your child.**

Permission forms will also be available on the Archdiocese of Louisville website at www.archlou.org and/or the Louisville Metro Department of Public Health and Wellness's website at www.louisvilleky.gov/health.

Some children, dependent upon their age, may need two doses of vaccine spaced at least three to four weeks apart. Information concerning a second vaccination will come at a later date; however, we do not anticipate school-wide clinics for any second vaccinations.

Once the vaccine clinic is held, a notice will be sent home with your child to let you know they received the vaccine. In the event that the child does not receive the vaccine for some reason, the notice will identify the reason. For example, if the documents were not completely filled out, if the child refuses the vaccine, or if the type of vaccine requested (mist/injection) is not available that day, etc. If you have any questions about the logistics (date, time, location) for the vaccination clinics, please call your child's school.

If you have medical questions about the vaccine, please consult your child's medical provider, the H1N1 fact sheet in this packet, the LMDPHW H1N1 hotline (568-4161), the Kentucky Health Department hotline (1-877-843-7727), www.flu.gov, or www.cdc.gov. School and archdiocesan personnel will not be able to answer any medical questions regarding the H1N1 vaccine. **Please consult with your child's provider before signing the permission form especially if your child has any health conditions. Additional information or documentation from your child's health care provider may be needed depending upon the health condition.**

Sincerely,

Leisa Schulz
Superintendent



If this document is incomplete in any section the vaccine will not be administered. No telephone or proxy request for the vaccine will be accepted

SCHOOL FORM

School Site _____

H1N1 Influenza Vaccine ADMINISTRATION RECORD

STUDENT'S NAME: _____

ADDRESS: _____

STREET CITY COUNTY STATE ZIP
AGE: _____ **BIRTHDATE:** ____/____/____ **CONTACT PHONE NUMBER** _____
MONTH DAY YEAR

RACE: (Check ONE or MORE) (W) White (B) Black or African American (N) American Indian or Alaska Native
 (A) Asian (H) Native Hawaiian or Other Pacific Islander **ETHNICITY:** Hispanic or Latino (Y) Yes or (N) No

SEX: (Check ONE) Male Female

- Y N**
- Has your child had a previous H1N1 vaccine? ____ Nasal ____ Shot DATE: _____
 - Does your child have a serious allergy to eggs?
 - Does your child have any other serious allergies? Please list _____
 - Has your child ever had a serious reaction to a previous dose of flu vaccine?
 - Has your child ever had Guillain-Barre Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving a flu shot?
 - Has your child been vaccinated within the past 30 days? Vaccine _____ Date _____
 - Has your child had a flu vaccination within the past 30 days? Inactivated Influenza (shot) ____ Intranasal Vaccine (nasal mist) ____
 - Does your child have any of the following: asthma, diabetes, disease of the lungs, heart, kidneys, liver, nerves, or blood?
 - Is your child on long-term aspirin or aspirin containing therapy (does your child take aspirin every day)?
 - Does your child have a weak immune system (HIV, cancer, or medications such as steroids or those used to treat cancer)?
 - Is your child pregnant?
 - Does your child have close contact with a person who is immune compromised? (example: someone who has recently had a bone marrow transplant)?

If you answered "yes" to any of the above questions your child may not be able to receive the H1N1 vaccine at school.

Louisville Metro Department Public Health Wellness may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

I have read or have had explained to me the 2009-2010 Vaccine Information Statements (VIS) and understand the risks and benefits for each vaccine and consent for my child to have : (Check one)

- Either the Live, Intranasal H1N1 influenza vaccine or the Inactivated H1N1 influenza vaccine as explained in the 2009-2010 Inactivated H1N1 influenza vaccine, (VIS dated 10/2/09) and the Live, Intranasal H1N1 influenza vaccine, (VIS dated 10/2/09)**
- The Inactivated H1N1 influenza vaccine (shot) as explained in the 2009-2010 Inactivated H1N1 influenza vaccine, (VIS dated 10/2/09)**
- The Live, Intranasal H1N1 influenza vaccine (nasal mist) as explained in the 2009-2010 Live, Intranasal H1N1 influenza vaccine, (VIS dated 10/2/09)**

X _____ **DATE:** _____

Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian)

I acknowledge (with my initials) that a HIPAA Privacy Notice was provided to me. _____

I DO NOT GIVE CONSENT to Louisville Metro Department of Public Health and Wellness and Jefferson County Public Schools for my child named at the top of this form to be vaccinated with this vaccine.

Are you getting the vaccine elsewhere for your child? Yes No

DATE: _____

Signature of parent or legal guardian

FOR Louisville Metro Department of Public Health and Wellness USE ONLY

Vaccine Manufacturer: _____ Vaccine Lot Number: _____

Injection Site: _____

Signature and Title of Provider: _____ Provider# : _____

NOTES: _____