



BERKSHIRE HILLS REGIONAL SCHOOL DISTRICT

GREAT BARRINGTON • STOCKBRIDGE • WEST STOCKBRIDGE

50 MAIN STREET • P.O. BOX 617 • STOCKBRIDGE, MA 01262 • (413) 298-4017

November 3, 2009

Berkshire Hills Regional School District Community,

Our schools and school nurses have received many questions regarding the H1N1 virus. This memo should serve as a source of information regarding the H1N1 flu. The most frequent question is whether or not we have students with confirmed cases of H1N1. H1N1 testing is rarely done and usually only in extreme cases. We have been told by Fairview Hospital staff that it is too early in the year for seasonal flu and that students who are out with flu-like symptoms should be presumed to have the H1N1 virus. We are closely monitoring students in all three buildings who are absent with flu-like symptoms and at this time we are not planning on school closures. We have asked parents to please keep children home from school if they have flu-like symptoms and that they stay home at least until they have gone 24 hours without a fever and without taking any fever reducing medication. We are also asking parents to keep the school nurses informed regarding their children's symptoms including fever, sore throat, runny nose, coughing etc.

When the vaccine becomes available in larger quantities in Southern Berkshire, we will host immunization clinics at each of our three school buildings. Attached you will find the H1N1 Vaccination Consent Form and a Permission to Share H1N1 Vaccine Information Form. A full set of forms will also be available at the clinics which will include the 2009-2010 Vaccine Information Statement. The vaccine will be available to all students, parents and staff members that want it. If you are interested in receiving the vaccine, please bring the consent form with you on the date of the clinic. **Do not mail the forms to the schools.**

Thank you for your patience during uncertain times. Please feel free to contact the school nurses, your health care provider or reach out to me directly if you have questions.

Sincerely,
Peter Dillon
Peter Dillon, Ed.D.,
Superintendent



PERMISSION TO SHARE H1N1 VACCINE INFORMATION
(FOR ADULT IMMUNIZATION)

I, _____, give permission to the individual and/or entity
(Print your name)

that administered the 2009 H1N1 vaccine to me to share copies of the 2009 H1N1 vaccination record with my health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 vaccination record with each other.

My health care provider:

Name: _____

Address: _____

- This health information is disclosed at my request and to ensure that I am appropriately vaccinated.
- This permission expires one year from the signature date.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

(School/Institution/Individuals handling withdrawals MUST insert name and address above.)

However, if I withdraw permission at a later date, any vaccine record already shared will not be covered by the withdrawal.

Print Name

Signature

Address

Date

Permission to share is compliant with HIPAA for billing and information sharing purposes.

Patient Name: _____ Date of Birth: ____/____/____

**Screening Questionnaire / Consent for
Seasonal and H1N1 Influenza Injectable Vaccination**

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should give you or your child injectable influenza vaccination today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillain-Barré Syndrome:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Given by: _____

Site: RT Deltoid Lot# _____ Exp: _____
 LT Deltoid
 Other _____

Technical content reviewed by the Centers for Disease Control and Prevention, September 2009.

Adapted by MDPH from Screening Questionnaire for Injectable Vaccination from the Immunization Action Coalition (9-09)—www.immunize.org

2009 H1N1 Flu Vaccine Consent Form — Injectable Flu Shot Only

Section 1: Information about Child to Receive Vaccine (please print')

Student's Name: (Last)	(First)	(M.I.)	Student's Date of Birth / /	
Parent/legal Guardian's Name (Last)	(First)	(M.I.)	Student's Age	Student's Gender M / F
Address			Parent/Guardian Daytime Phone Number:	
City:	State:	Zip:		
School Name:			Grade/Class	

Section 2: Screening for Vaccine Eligibility

If your child has already been vaccinated with 2009 H1N1 flu vaccine, please tell us the number of doses and dates of vaccination.

- Dose 1 Date received: month__day__year__ Form (please circle): nasal spray shot
 Dose 2 Date received: month__day__year__ Form (please circle): nasal spray shot

The following questions will help us know if your child can get the 2009 H1N1 flu vaccine. Please mark YES or NO for each question.

If you answer "YES" to one or more of the four questions, your child will not be able to receive the 2009 H1N1 flu vaccine in school unless there is a note from your child's health care provider approving the vaccination. If you answer "NO" to the following questions your child will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your child's healthcare provider.

	YES	NO
1. Does your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a serious reaction to a previous does of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

List other serious allergies: _____

Section 3: Consent:

CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the H1N1 flu vaccine and understand the risks and benefits.

I GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. Children younger than 10 years of age need 2 doses of vaccine. (If this consent is not signed, dated and returned, then your child will not be vaccinated.)	I DO NOT GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine.
_____ Signature of Parent/Legal Guardian	_____ Signature of Parent/Legal Guardian
Date: month ____ day ____ year ____	Date: month ____ day ____ year ____

PLEASE BE SURE TO READ AND SIGN THE REVERSE SIDE OF THIS FORM

Section 4: Permission to Share Information:

I, _____, give permission to the individual and/or entity that administered the
(Print your name)
2009 H1N1 vaccine to my child _____ to share copies of the 2009 H1N1 consent form and
(Print child's full name)

Vaccination record with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local Board of Health in my community. I also give permission for each of these entities to share the 2009 H1N1 consent form and vaccination record with each other.

My child's Health Care Provider:

My child's school:

Name: _____

Address: _____

(at minimum include Town)

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of 2009-2010 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign the authorization and that my refusal to sign will not affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

(School/Institution/Individuals handling withdrawals MUST insert name and address)

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal

Printed Name of Parent or Guardian

Signature of Parent or Guardian

Address

Date