

LIFE SCHOOL LANCASTER

From the Principal...

September 15, 2011

Good afternoon parents, and I hope all is well. We have partnered with the Dallas Carevan Immunization Outreach to offer flu vaccinations for our students. The vaccination will be offered during school hours on October 18th, and will come in the form of a nasal mist (intranasal influenza vaccine). Flu shots will be available only to those students who have asthma. This is purely an optional (free) vaccination to those who are eligible (see documentation for eligibility on reverse side), sign a consent form and **parent/guardian is present. No immunizations will be administered without parent/guardian supervision.** If you are interested, please return your consent form (attached on back) to your homeroom teacher no later than Friday, September 30th. Upon receiving your consent form, you will be notified of the immunization time for your child(ren). (For more information about influenza vaccinations go to www.imunize.org/vis.)

Mr. Parker



The Nurse's Station

Water is essential to every function of the body and is called the most essential nutrient. Water makes up 80% of the blood, 70% of the brain, and 90% of the lungs. Slight dehydration can impair concentration. As humans we can go a month without food, but only days without water. Water is inexpensive and calorie-free. Consider water for your students over any of the sugary, carbonated beverages.



Important Dates:

- Aug. 29th - Sept. 30th - AN / Hearing / Vision / Spinal screenings
- Sept. 19th-Oct. 5th- Fall Fundraiser
- September 21st- Founder's Coffee 8:30 a.m. - 9:30 a.m. in the Gym
- September 23rd- Staff Development- **NO SCHOOL**
- Sept. 29th- Parenting Night for Kinder, 2nd, and 3rd Grades **ONLY**
- September 30th- Birthday Friday!!

Character Counts!
RESPONSIBILITY

"I will show self-discipline."





DALLAS CAREVAN IMMUNIZATION OUTREACH

TEACHER: _____

Influenza Vaccine Registration and Consent

(Information about the person who will receive the vaccine- PLEASE PRINT)

LAST NAME	FIRST NAME	BIRTHDATE	SEX	AGE
ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

TVFC ELIGIBILITY	HEALTH SCREENING (Circle YES or NO for ALL questions)
<ul style="list-style-type: none"> <input type="checkbox"/> Enrolled in Medicaid <input type="checkbox"/> Child has NO health insurance <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Child has CHIP benefits <input type="checkbox"/> Under-Insured (has insurance that does not pay for vaccines, OR has a co-pay or deductible that the family cannot meet, OR has insurance that provides limited wellness or prevention coverage. <input type="checkbox"/> Patient is served by any type of Public Health Clinic and DOES NOT meet any of the above criteria. <input type="checkbox"/> Has private insurance or can pay for services. (Children who have checked this box are not eligible for Texas Vaccine for Children/CareVan services.) 	<ol style="list-style-type: none"> 1. Has your child had a life-threatening reaction to influenza vaccine? YES NO 2. Does your child have a severe, life-threatening allergy to eggs or latex? YES NO 3. Has your child ever had a seizure or brain disorder? YES NO 4. Does your child have a long-term health problem such as: Heart disease, Lung disease, Asthma, Kidney disease, Neurologic disease, Liver disease, Diabetes, Anemia or other blood disorder? YES NO Please explain: _____ 5. If your child is younger than 5 years old, has he or she had an episode of wheezing in the past year? YES NO 6. Does your child have a weakened immune system because of HIV/AIDS, cancer treatment or long-term treatment with drugs such as steroids? YES NO 7. Is your child in close contact with someone with a severely weakened immune system? (For example, a bone marrow transplant) YES NO 8. Is your child pregnant or could she become pregnant in the next month? YES NO 9. Has your child received any other vaccinations in the past 28 days? YES NO If yes, please list: _____ 10. Is your child taking aspirin or aspirin-containing medicine right now? YES NO

I have been given a copy and have read or have had explained to me the information in the Vaccine Information Statement (VIS) for the 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 the influenza vaccine and request that the influenza vaccine be given to me or to the person named above for whom I am authorized to make this request. I understand that information relating to this vaccine may be stored electronically and may be used or disclosed in accordance with the law.

X _____ DATE: _____
SIGNATURE of person receiving vaccine, if 18 years old, OR Parent OR Guardian who is authorized to consent to this procedure.

PLEASE PRINT NAME OF PERSON SIGNING CONSENT: first name: _____ Last Name: _____

FOR OFFICIAL USE ONLY

Manufacturer	Lot # and Exp. Date	Dose/Route	Site Used	DATE:
Sanofi-Pasteur		0.25ml - IM	RD LD	ADMINISTRATOR, Signature and Printed
GSK		0.5 ml - IM	RT LT	
Novartis		0.2 ml - IN	NASAL	
Medimmune				