Avoid The Flu!

Get the FREE flu shot here

Tuesday November 3rd

- Available for students in Kindergarten–5th Grade
- Consent forms coming home October 14th
- **Consent forms are due back by October 28th**
- Consents can be:
  - Returned to school in your student's folder
  - OR emailed to health@cd-csd.org

- Not Interested? No problem! No action neccesary

Questions? Please contact the school health office or email us at health@cd-csd.org

CENTRAL DEWITT
COMMUNITY SCHOOL DISTRICT
331 East 8th Street, Box 110, DeWitt, IA 52742

Phone: 563-659-0700
Fax: 563-659-0707
www.cd-csd.org

Dear Parents of Kindergarten through 5th grade students,

Central DeWitt Community School District is partnering with Genesis VNA/Public Health to offer Kindergarten through 5th grade students flu vaccines at school, free of charge.

Genesis VNA/Public Health is scheduled to vaccinate students on **November 3rd, 2026.** If you would like your student to participate, please complete the consent form and return it to the school office or email the consent to health@cd-csd.org **NO LATER than October 28, 2026.** Late orders will not be accepted. This is an optional vaccine. No action is needed if you choose not to participate in the flu clinic.

Attached is the consent form.

For more information about the flu vaccine visit:
https://www.cdc.gov/vaccines/hcp/current-vis/downloads/flu.pdf

If you have any questions or concerns, please contact Ann Bixby the District Nurse at ann.bixby@cd-csd.org or at 563-659-4744.

Thank you,

Ann Bixby RN
Central DeWitt Community School District Nurse

MERCYONE GENESIS

Student Flu Vaccine Consent & Release Form

PLEASE PRINT **COMPLETE FORM FOR EACH CHILD**

STUDENT'S NAME (Last)	(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** / /	
PARENT/GUARDIAN'S NAME (Last)	(First)	(M.I.)	**Circle Gender** M F	**Student's Age**
ADDRESS			**PHONE:**	
CITY and STATE	**ZIP**		**Daytime:** **Home:** **Cell:**	
SCHOOL NAME				

This vaccination program is free to all elementary students; however, for program purposes we need the following information. Please check the section that applies to your child: ( ) Medicaid Enrolled ( ) No health insurance ( ) American Indian/Alaskan Native ( ) Has health insurance that does NOT pay for influenza vaccines

( ) Has health insurance that DOES pay for influenza vaccines The following questions will help us to determine if your child can get the influenza vaccine.

Please mark **YES** or **NO** for each question:	**YES**	**NO**
1. Does your child have a serious allergy to eggs?		
2. Does your child have any other serious allergies? Please list:		
3. Has your child ever had a serious reaction to flu (influenza) vaccine in the past?		
4. Has your child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)?		

Consent for Child's Vaccination

I have read the Vaccine Information Statement for the ***Inactivated Influenza Vaccine for the 2026-27 season*** or have had the information explained to me. I have had a chance to ask questions, which were answered to my satisfaction. I understand and acknowledge the benefits and risks of influenza vaccine and request that the vaccine be given to my child at school. I accept responsibility for seeking medical attention for any problems with this vaccination. I understand that if my child requires two doses of flu vaccine, it is my responsibility to get this second dose for my child. I acknowledge that I have read a Genesis Health System Notice of Privacy Practices. **I give consent for my child, for whom I am authorized to make this request, to be vaccinated by Mercyone Genesis staff.**

Signature of Parent/Guardian _____ Date: ____/____/____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Site	Route	Vaccine Manufacturer	Lot Number	Expiration Date
2026-2027 Inactivated Influenza	/ /	RD LD	IM 0.5 ml			
Name & Title of Vaccine Administrator:						