

SPRUCE MOUNTAIN SCHOOL DISTRICT

Regional School Unit No. 73

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11/8/2021

Dear RSU 73 Staff, Students, and Families,

This letter is to inform those families with students aged 5 to 11 of an opportunity to vaccinate your child from Covid-19. Franklin Memorial Hospital is offering a school vaccination outreach clinic. The Pfizer vaccination has recently been approved for people ages 5 to 11. We will be able to offer the first shot of the Pfizer vaccination on Friday afternoon, November 19th, 2:45pm to 6pm. for those students who sign up and have parent's permission. The clinic will take place in the SMHS gym. Please go in the back entrance by the parking lot between the SMHS & SMMS. We have put the hours afterschool so that parents can attend with their child. The second shot will be offered on December 10th.

I want everyone to understand that we are only offering an opportunity for this to happen if **you** want your child vaccinated. It is not our intent to mandate or pressure anyone into getting the vaccine. We just know it is sometimes difficult to get an appointment or that the appointment interferes with a parent's work schedule. FMH will be running the clinic in a number of Franklin County schools to help expedite the process. Paperwork will be available on our RSU 73 Facebook page, this e-mail and hard copies will be sent home with students.

Sincerely,

Scott Albert
Superintendent



PATIENT LABEL HERE

COVID-19 VACCINATION

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- I. **DESCRIPTION, PURPOSE AND EXPECTED BENEFITS OF VACCINE PROCEDURE.** I understand that I will receive a vaccine by needle injection, which is intended to reduce the chances of my becoming ill due to a COVID-19 infection. COVID-19 infections can have [serious, life-threatening complications](#). Depending upon the particular COVID-19 vaccine, I may require either one or two injections. I agree to remain at the vaccination location for at least 15 minutes after the vaccine is administered so that I could be attended to if I had an adverse reaction to the vaccine.
- II. **POTENTIAL RISKS AND LIMITATIONS ASSOCIATED WITH THE PROCEDURE.** I understand that I may experience soreness, redness, and/or swelling at the injection site. The other significant known and potential risks and benefits of the vaccine, and the extent to which such risks and benefits are unknown, is described in an FDA Emergency Use Authorization (EUA) Fact Sheet. I have received and read the Fact Sheet and a pre-vaccination checklist for the vaccine. If I have any further questions about the procedure, I will ask them before undergoing the vaccination. It is unclear how long any potential benefits of the vaccine may last; or whether it will be effective against mutating forms of the COVID-19 virus. I understand that I may still become ill with COVID-19, and may be able to transmit the virus to other individuals. **For this reason, the vaccine does not eliminate the need for physical masking, social distancing, and hand hygiene.**

III. **TREATMENT ALTERNATIVES.** I understand that I may refuse the COVID-19 vaccine. There currently are no known effective alternatives to prevent COVID-19 infections, other than physical masking, social distancing, and hand hygiene.

IV. **PRECAUTIONS/CONTRAINDICATIONS** *Vaccine may not be indicated depending on your responses.*

Fever or feeling ill today?	<input type="checkbox"/> No or <input type="checkbox"/> Yes – if yes, then defer until feeling better.
History of an allergic reaction (e.g., anaphylaxis, hives, itching) to any component of this vaccine?	<input type="checkbox"/> No or <input type="checkbox"/> Yes – if yes, then STOP, do NOT vaccinate.
History of any immediate allergic reaction to another vaccine?	<input type="checkbox"/> No or <input type="checkbox"/> Yes – if yes, then consult with physician and consider deferral of vaccination.
History of any immediate allergic reaction to an injectable therapy or IV contrast?	<input type="checkbox"/> No or <input type="checkbox"/> Yes – if yes, then consult with physician and consider deferral of vaccination.
History of anaphylaxis?	<input type="checkbox"/> No or <input type="checkbox"/> Yes – if yes, then observe for 30 minutes.

V. **USE OF HEALTH INFORMATION.** I understand that record of this vaccine administration will be reported to the state and/or federal regulatory bodies. I authorize my COVID-19 vaccine record to be shared with my primary care physician; and to be used or shared for payment, quality of care, patient safety, and research purposes. Otherwise, the information will be handled in accordance with the MaineHealth Notice of Health Information Privacy Practices, available online at <https://www.mainehealth.org/-/media/Maine-Medical-Center/Files/Psychiatry/Notice-Privacy-Practices-2017.pdf>, with printed copies also available on request.

VI. **PHONE CONTACT.** I consent to being contacted by MaineHealth or its agents by telephone (cell or landline), text message, or voice message at the telephone number previously provided. This consent applies to those individuals who are acting on my behalf.

Emergency Contact Name: _____ **Emergency Contact Phone Number:** _____

X

Date _____ Time AM|PM _____ Signature Patient Parent Guardian Authorized Representative _____ Printed Name _____

If by telephone consent given by: Patient Other _____ Phone number _____

X

Date _____ Time AM|PM _____ Witness Signature (For phone consent or when patient is physically unable to sign) _____ Printed Name _____

Interpreter for: Sign Language Foreign Language Other _____ Print Name or identifying information _____

X

Date _____ Time 24 Hour _____ Signature of Physician or Designee _____ Printed Name _____

For Staff Use Only:
 Patient **had** an immediate adverse reaction to the vaccine. Patient **did not** have an immediate adverse reaction to the vaccine.

MaineHealth

COVID-19 Vaccine Registration Form

Patient First Name	
Patient Middle Initial	
Patient Last Name	
Patient Date of Birth	
Patient (Legal) Gender	
Last 4 Digits of Social Security #	
Patient Language	
Interpreter Needed (Yes/No)	
Patient Race	
Patient Ethnicity	
Mailing Address: Street Address	
Mailing Address: City	
Mailing Address: State	
Mailing Address: Zip Code	
Mailing Address: County	
Physical Address (if different from mailing address):	
Phone Number: Mobile	
Phone Number: Home	
Insurance Identification Number/ Policy Number/ Member ID #	
Insurance Company Name	
Ethnicity:	<ul style="list-style-type: none"><input type="radio"/> Hispanic<input type="radio"/> Non-Hispanic<input type="radio"/> Unknown
Race:	<ul style="list-style-type: none"><input type="radio"/> American Indian or Alaska Native<input type="radio"/> Asian<input type="radio"/> Black or African American<input type="radio"/> Multi-Racial<input type="radio"/> Native Hawaiian or Other Pacific Islander<input type="radio"/> White or Caucasian<input type="radio"/> Unknown