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www.SBCounty.gov

SAN BERNARDINO COUNTY

Public Health
Communicable Disease Section - Immunizations Program

San Bernardino County Department of Public Health Agreement on Use of Seasonal Influenza Vaccine Purchased by the California Department of Public Health

Seasonal influenza vaccine is distributed by the California Department of Public Health (CDPH) to local health departments (LHD) for use by LHDs and community providers in accordance with LHD policies and procedures. As a condition for receipt of the influenza vaccine for the **2025-26 season** from San Bernardino County Department of Public Health, the provider shall agree to the following terms:

1) For each influenza immunization given, the provider will retain a record which includes the manufacturer name and the lot number used.

2) Physician/Director will charge no vaccinee or third party more than $2.00 as a fee for administering the vaccine, or what is authorized by County Board of Supervisors (as noted by Government Section Code 54985) or what is authorized by Medicare (refer to exceptions as noted on Centers for Medicare and Medicaid Services (CMS) website: www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing). No charge will be made for the vaccine itself. In addition, the provider agrees to comply with the Federal requirements regarding people aged 65 and older who have Part B Medicare coverage. No Medicare Part B beneficiary, age 65 or older, should have to pay out-of-pocket expenses for receipt of influenza vaccine.

3) Physician/Director agrees that their staff will follow CDPH standards for storage and handling of vaccine, including standards related to the transport of vaccine to community locations for mass vaccination clinics. Physician/Director agrees that their staff will review immunization resources and training found at eziz.org

4) Physician/Director agrees that their staff will complete **weekly electronic vaccine usage reports by 5 p.m. every Monday, or within 3 days of a mass influenza clinic**. Final reports due by July 6, 2026. The **2025-2026 Influenza Vaccine Weekly Usage Report Form** can be accessed online with the link 25-26 Influenza Vaccine Weekly Usage Report Form or found directly from San Bernardino County's website at: dph.sbcounty.gov/programs/communicable-disease/immunization-services.

5) All doses administered will be documented in the local immunization registry per California Health and Safety Code Section 120392.3. All State General Fund (SGF) doses must be recorded as SGF doses in CAIR: www.cdph.ca.gov/Programs/CID/DCDC/CAIR/Pages/CAIR-updates.aspx.

6) Medical judgment will be exercised in prescribing influenza immunizations. Each person (or legal guardian) receiving influenza vaccine will be given a copy of the most recent Vaccine

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Information Statement "**Influenza Vaccine (Inactivated or Recombinant)**" which can be obtained from online from https://www.cdc.gov/vaccines/hcp/current-vis/index.html or www.immunize.org/vis/.

(a) Each person to be immunized will be allowed adequate time for reading the information and asking questions before signing the statement.
(b) All documentation will be retained for a period of at least three (3) years.

4) Note on Vaccine Reaction Surveillance: Facilities administering influenza vaccine are asked to call or email the LHD at 800-722-4794 or Immunizations@dph.sbcounty.gov promptly to report any adverse health events experienced by influenza vaccines that occur within 4 weeks of immunization and require medical attention. Adverse reactions should also be reported to the Vaccine Adverse Event Reporting System **(VAERS)** at: vaers.hhs.gov/reportevent.html.

5) San Bernardino County Department of Public Health:
   (a) Has the right to audit and review storage and handling of influenza vaccine.
   (b) Must be notified when State purchased influenza vaccine leaves your clinic. San Bernardino County must approve of all vaccine transfers prior to transfers taking place. Vaccine transfers including but not limited to mass vaccination events or supplying other providers.

Clinic Name: _____

Clinic Address: _____

City: _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

Email address: _____

myCAvax ID: _____ **CAIR ID (IIS ID):** _____

Physician/Medical Director Name: _____

Physician License Number: _____

Physician Signature: _____ **Date:** _____