SEASONAL INFLUENZA ENCOUNTER 2019-2020 FORM

Client Name: (last, first, MI)				
Address: (street, city, state)				
Phone #:		Cell Phone:	Gender: M F	Race:
Name of Insurance:		Policy #:	Group #:	
Name of Policy Holder:		Policy Holder Date of Birth:		
Client Birth Date:		SSN#:		

ALLERGIES:

I hereby authorize vaccinators working under the direction and supervision of licensed health care providers of the Virginia Department of Health to immunize me or my child named above. I understand the risks and benefits of the immunizations checked below and have had the opportunity to ask questions. I have received VACCINE INFORMATION STATEMENTS or information sheets about the immunizations. I agree that my or my child's immunization record and date of birth may be shared with other health care providers. I understand that this information will be used by health care providers for the care of me or my child. I understand that this information will be kept confidential. The Deemed Consent for blood borne diseases has been explained to me and I understand it. I understand that medical records must be kept for a period of 5 years after my last visit or until age 21, if a minor. I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third party payer to pay any authorized benefits to VDH on my behalf. ***You may be liable for charges if not insured or not covered by a third party payer.***

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices from the Virginia Department of Health

SCREENING QUESTIONNAIRE

Please check the appropriate box.	**Yes**	**No**	**Don't Know**
1. Have you ever had an allergic reaction to any component of flu vaccine (eggs, gentamicin, gelatin, arginine)?			
2. Have you ever had a serious reaction to influenza vaccine in the past?			
3. Have you ever had Guillain-Barré Syndrome?			
4. Are you taking aspirin or other aspirin-containing products?			
5. Are you taking any prescription medications to prevent or treat flu?			

_____ _____

Patient Signature/ Parental signature for Minors Date

VACCINE ADMINISTERED				
Item Code	**Lot Number**	**Route**	**Administration Site**	**Payer**
FLU-PFA- Preservative Free-Adult		IM	☐RA ☐ LA	☐C ☐Adult Free
FLU-PFP Preservative Free-Ped		IM	☐RA ☐ LA	☐C ☐VFC
QFLU-MULTI 90687 6-35 mos (0.25 ml)		IM	☐RA ☐ LA	☐C ☐ VFC
QFLU-MULTI 90688 3 yrs & older (0.5 ml)		IM	☐RA ☐ LA	☐C ☐ VFC

_____ _____ _____

Provider Signature Provider Number Date