2020-2021 Mass Immunization Clinic Encounter Form
(Non-school Based)
Informed Consent for Influenza Immunization

VDH Client ID:		Client Name: (last, first, MI)					
Birth Date:		Address: (street, city, state, zip)					
Home Phone:		Cell Phone:		Gender: M F		Date of Service	
SSN# (optional)							

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.

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 tests.

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

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

VACCINES ADMINISTERED

☐**Seasonal Influenza** Influenza Vaccine ICD10**: Z23**
Immunization. Admin Code**: 90471/90473 (inj/mist)** Medicare Immunization Admin Code**: G0008**

Item Code	Lot Number	Route	Administration Site	Provider #
QFLU-MULTI - 6 - 35 mos (0.25 mL)		IM	☐ RA ☐ RL ☐ LA ☐ LL	
QFLU-MULTI - 3yrs & older (0.5 mL)		IM	☐ RA ☐ LA	
QFLU-SP - Preservative containing – (0.5 mL)		IM	☐ RA ☐ LA	
QFLU-PFP - Preservative Free – Pediatric (0.25 mL)		IM	☐ RA ☐ RL ☐ LA ☐ LL	
QFLU- PFA - Preservative Free – (0.5 mL)		IM	☐ RA ☐ LA	
FLU-MIST – nasal mist (0.1ml per nostril)		NS	Nose	
Other:				
			☐ RA ☐ LA	
☐ Virginia Vaccines for Children ☐ 317 ☐ STATE ☐ LHD ☐ EP&R				

Parent/Legal Guardian, Person Acting in Loco Parentis -Printed Name Signature Date

Provider Printed Name Signature Date

CHS-2b (07/16/20)

INSURANCE INFORMATION & SCREENING QUESTIONNAIRE ON BACK

SCREENING QUESTIONNAIRE - Inactivated Injectable Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable or live attenuated influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Please check the appropriate box.	**Yes**	**No**	**Don't Know**
1. Has the person to be vaccinated ever experienced severe allergic reactions to the vaccine or any of its components (**eggs** or egg protein, gentamicin, gelatin, arginine) or to a previous dose of any influenza vaccine?			
2. Has the person to be vaccinated ever had Guillain-Barré syndrome?			

Live Attenuated Intranasal Influenza Vaccination (ask above questions 1, and 2 and include the following)

Please check the appropriate box.	**Yes**	**No**	**Don't Know**
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?			
4. Is the person to be vaccinated younger than age 2 years or older than age 49?			
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?			
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?			
7. Does the person to be vaccinated have a weakened immune system? For example, HIV/AIDS or another disease affects the immune system, as does long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs.			
8. Is the person to be vaccinated receiving antiviral medications (for example Tamiflu® or Relenza®) ?			
9. Is the child to be vaccinated between the ages of 2 – 17 years receiving aspirin therapy or aspirin-containing products?			
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?			
11. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?			

*As a reminder, it is recommended that you wait at least 15 minutes before leaving the area after vaccination.

PLEASE COMPLETE THE INSURANCE SECTION BELOW (This section ***does not*** apply to Emergency Preparedness & Response-EP&R clinics).

INSURANCE INFORMATION		
Third Party Payer	**Policy Number**	**Effective Date**
Medicaid (children or high-risk adults only)		
Medicaid HMOs (children and adults): specify Plan Name Plan name:		
Medicare Part B		
Private health insurance: specify Plan Name Plan name:		
☐ None of the above		

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.

Form completed by: ______________________________________ Date: ___________________________

Form reviewed by: _______________________________________ Date: ___________________________