



SEASONAL INFLUENZA ENCOUNTER



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

Date

VACCINE ADMINISTERED

Item Code	Lot Number	Route	Administration Site	Payer	
QFLU-PFA- Preservative Free-6 mos & up		IM	<input type="checkbox"/> RA <input type="checkbox"/> LA	<input type="checkbox"/> C	<input type="checkbox"/> EP&R
FLU MIST		NASAL		<input type="checkbox"/> C	<input type="checkbox"/> VFC

Provider Signature

Provider Number

Date

NRHD 8/25/20