

2023-2024 Mass Immunization Clinic Encounter Form



	-		(Non-school B		:4:	VL	OF HEALTH
VDH Client ID:		Client Nam	ormed Consent for Influer Client Name: (last, first, MI)		ization		
Birth Date:		Address: (street, city zip)	(street, city, state,				
Home Phone:		Cell Phone:	•	Gender:	M F	Date of Service	
Preferred loc	ation: 🖵 Chathan	n 🗖 Dan River 🖣	Gretna 🗖 Tu	nstall SSN# (d	optional):		
Department of checked below information sk shared with ot of me or my ch diseases has b	f Health to immuni v and have had the neets about the imm ther health care pro- hild. I understand to neen explained to m	ze me or my child opportunity to ask nunizations. I agreoviders. I understathat this informatione and I understanage 21, if a minor.	named above. I k questions. I have that my or my and that this info on will be kept co d it. I understand	understand the ve received VAC child's immuni rmation will be onfidential. The did that medical	risks and CCINE IN zation rece used by h Deemed records mi	benefits of the FORMATION ord and date of the ealth care proceed to the consent for bust be kept for	N STATEMENTS or of birth may be oviders for the care blood borne
1. If any VDH transmit disease physician or oth consented to the 2. If you should transmit disease	d by § 32.1-45.1 of the health care profession	onal, worker or employed tested for infection der will tell you the esults to the person of to blood or body flower will be tested for in	(1950), as amend loyee should be di with human immuresult of the test. exposed. uids of a VDH henfection with human immuresult of the test.	ed, to give you to rectly exposed to modeficiency via Under Va. Code alth care profess an immunodefic	he followin by your blood rus (HIV), a § 32.1-45.1 ional, work iency virus	g notice: d or body fluid as well as for H l(A), you are d ter or employee	In a way that may

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

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

VA	ACCINES ADMINISTER	RED								
□Seasonal Influenza										
Item Code	Lot Number	Route	Administration Site	Provider #						
QFLU-MULTI - 6 - 35 mos (0.25 mL or 0.50 mL) circle Fluzone dose given		IM	□ RA □ RL □ LA □ LL							
QFLU-MULTI - 3yrs & older (0.5 mL)		IM	□ RA □ LA							
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										
X										
Patient, Parent/Legal Guardian, Person Acting in Loco	Parentis -Printed Name	Sign	ature	Date						
Provider Printed Name	Sig	Date								
CYY 21 00 40 40 40 40 40 40 40 40 40 40 40 40										

CHS-2b 08/30/2023

SCREENING QUESTIONNAIRE - Inactivated Injectable Influenza Vaccination

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

2. Has the person to be vaccinated ever had Guillain-Barré syndrome?

Please check the appropriate box.

any influenza vaccine?

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.

No

Yes

Don't Know

lease check the appropriate box.	Yes	No Don	ı't Know	
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine (FluMist) in the past?	intranasal			
4. Is the person to be vaccinated younger than age 2 years or old	ler than age 49?			
5. Does the person to be vaccinated have a long-term health prodisease, lung disease, asthma, kidney disease, neurologic or n disease, liver disease, metabolic disease (e.g., diabetes), or an blood disorder?	euromuscular			
6. If the person to be vaccinated is a child age 2 through 4 years months, has a healthcare provider ever told you that he or she asthma?				
7. Is the person to be vaccinated a child age 5 years or older with	h asthma?			
8. Does the person to be vaccinated have a weakened immune so For example, HIV/AIDS or another disease affects the immun non-functioning spleen or no spleen, or long-term treatment was or cancer treatment with radiation or drugs.	e system, as does having a	eroids,		
9. Has the person to be vaccinated taken any antiviral medicatio Tamiflu® or Relenza®) in the last 3 weeks?	ns for influenza (for example			
10. Is the child to be vaccinated between the ages of 2 – 17 year aspirin-containing products?	rs receiving aspirin therapy or			
11. Is the person to be vaccinated pregnant or could she become the next month?	pregnant within			
12. Has the person to be vaccinated received any other vaccination	ions in the past 4 weeks?			
13. Does the person to be vaccinated care for severely immunoc protected environment?	re a			
14. Does the person to be vaccinated have a cochlear implant?				
15. Does the person to be vaccinated have a cerebrospinal fluid surrounds the brain to the nose, throat, ear or some other loc				
*As a reminder, it is recommended that you wait at least				
EASE COMPLETE THE INSURANCE SECTION BELOW sponse-EP&R clinics).	(This section <i>does not</i> appl	ly to Emergency	y Preparedness &	
•	NCE INFORMATION			
Chird Party Payer	Policy Number		Effective	Date
Medicaid (children or high-risk adults only)				
Medicaid HMOs (children and adults): specify Plan Name				
lan name:				
Medicare Part B or Medicare Advantage-list plan name rivate health insurance: specify Plan Name				
lan name:				
None of the above	•		'	
uthorize VDH to release records necessary to support the applicate third-party payer to pay any authorized benefits to VDH on my be	tion for payment by Medicare, behalf.	Medicaid, and of	her health care ben	efits. I request
rm completed by:	Date:			