Rappahannock-Rapidan Health District
DRIVE-THROUGH Flu Clinic – November 3, 2008

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (Please Print)			
Last Name:	**First Name:**	**Middle Initial:**	**Male / Female**
City, State, Zip:		**Birth Date:**	**Phone#**

Please complete the information below if you are receiving a flu shot. See back for additional information.

1. I have received the influenza Vaccine Information Statement and my questions have been answered.
2. I have received the Notice of Privacy Practices from the Virginia Department of Health.
3. I understand the Deemed Consent for blood borne diseases.
4. I understand the benefits and risks of influenza vaccine and had the opportunity to ask questions.
5. I authorize that the influenza vaccine be given to me.
6. I understand that immunization records are kept 10 years after my last visit or five years after death.

Signature:	**Date:**
X_____	_____

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

1. If any VDH health care worker 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 (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Virginia 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 worker in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), 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.

Please answer these questions:	**Yes**	**No**
Are you sick with a fever today?	☐	☐
Can you eat eggs and egg products?	☐	☐
Have you had a flu shot before?	☐	☐
Have you ever had a SERIOUS reaction to a flu shot or vaccine?	☐	☐
Have you ever had Guillian Barre Syndrome?	☐	☐

FOR CLINIC/ OFFICE USE ONLY		
Event: Test of CRA	**Countermeasure:** Seasonal Influenza Vaccine	
Clinic Address: Lord Fairfax Community College, 6480 College St., Warrenton, VA	**Date:** 11/03/08	**Injection Site(circle one):** R L Deltoid
Vaccine Manufacturer: GlaxoSmithKline - Fluarix	**Vaccine Lot #:** AFLUA349CD	**Exp:** 05/31/09

_____ #_____ **Date:** **11/03/08**

Signature and Position number of Vaccine Administrator