

**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: X _____	Date: _____
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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?	<input type="checkbox"/>	<input type="checkbox"/>
Can you eat eggs and egg products?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a flu shot before?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a SERIOUS reaction to a flu shot or vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had Guillian Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>

FOR CLINIC/ OFFICE USE ONLY

Event: Test of CRA		Countermeasure: Seasonal Influenza Vaccine	
Clinic Address: Booster Park, 19046 Constitution Highway, Orange, VA		Date: 11/03/08	Injection Site(circle one): R L Deltoid
Vaccine Manufacturer: GlaxoSmithKline - Fluarix		Vaccine Lot #: AFLUA349CD	Exp: 05/31/09
Signature and Position number of Vaccine Administrator _____		# _____	Date: <u>11/03/08</u>