



2020-2021 Mass Immunization Clinic Encounter Form

Arrival: _____
Departure: _____



(Non-school Based) – POD
Informed Consent for Influenza Immunization

Client ID:
Client Name: (last, first, MI)
Birth Date:
Address: (street, city, state)
Phone (home or cell):
Gender: M F
Date of Service: 10/16/20

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 influenza vaccination today.

Please check the appropriate box.

Yes No Don't Know

Table with 2 rows of screening questions and 3 columns for Yes, No, and Don't Know responses.

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...
2. If you should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee...

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, the LENOWISCO Health District originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

- I have had the right to review the facility's Notice of Privacy Practices prior to signing this acknowledgement.
This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

PRINTED Name of Patient/Legal Representative Relationship to patient

SIGNATURE of Patient or Legal Representative Date

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.

Signature of Patient or Legal Representative Date

Table with 5 columns: Item Code, Lot Number, Route, Administration Site, Provider #

Provider Printed Name

Signature

Date