VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Health Department Use ONLY
CI# _____
Encounter # _____
Receipt #_____

SCHOOL EMPLOYEE 2014 SEASONAL INFLUENZA VACCINATION CONSENT FORM

SECTION A: CLIENT INFORMATION

Name (Last, First, Middle) :

Date of Birth: / / | Age: | Gender: ❑ M ❑ F

School: | Position:

SECTION B: CONTACT INFORMATION

Name (Last, First, Middle) :

Address: | City/State: | Zip:

Phone: | Home: | Work: | Cell:

SECTION C: INSURANCE INFORMATION

Employee's health insurance provider: _____ Medicare _____ UMWA _____ Black Lung _____ Anthem

____ Virginia Medicaid _____ Affordable Care Act _____ No Insurance

If Medicaid/Managed Care, please check which policy you have below.

____ Anthem HealthKeepers ____ Optima Family Care ____ Virginia Premier ____ Coventry Care ____ Majestacare ____ Intotal Health

Check below If you have Affordable Care Act Insurance (ID #: _____)

____ Anthem HealthKeepers ____ Optima Family Care ____ Virginia Premier ____ Coventry Care ____ Majestacare ____ Intotal Health

For all insurance plans, please complete this section for billing purposes:

Name of Insured/Policy Holder: _____ Insurance group #: _____

Relationship of policy holder: _____ Date of Birth of policy holder: _____

I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, or other health care benefits. I request the third party payer to pay any authorized benefits to VDH on my behalf.

Signature: X _____

SECTION D: CLIENT HEALTH HISTORY

Please mark either **Yes** or **No** for each question. Do not leave any question unanswered.

If you answer "NO" to all of the following questions, you can probably get the seasonal influenza vaccine. If you answer "YES" to one or more of the following questions, you may be able to get either the mist or injectable influenza vaccine, but that will be determined by health department nursing staff.

	Yes	No
1. Have you ever had a serious allergic reaction to eggs or to a component of the flu vaccine (egg protein, gentamicin, gelatin, arginine?	❑	❑
2. Have you ever had a serious reaction to a previous dose of flu vaccine in the past?	❑	❑
3. Have you ever had Guillian-Barre Syndrome (GBS, i.e., progressive ascending paralysis)?	❑	❑
4. Have you ever had a serious reaction to intranasal flu vaccine in the past?	❑	❑
4. Have you reached your fiftieth (50th) birthday?	❑	❑
5. Are you pregnant, or could you become pregnant within the next month?	❑	❑
6. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	❑	❑
7. Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	❑	❑
8. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g. an isolation room of a bone marrow transplant unit)?	❑	❑
9. Are you on long term aspirin therapy or taking other aspirin-containing medications? (Only applicable if you are under 17 years old, otherwise continue).	❑	❑
10. Are you taking any antiviral medications? (for example: Tamiflu or Relenza?)	❑	❑
11. Have you received any other vaccinations in the past 4 weeks?	❑	❑

Over

SECTION E: CONSENT FOR VACCINATION

I have read the **2014 Seasonal Influenza CDC Vaccination Information Statements (VIS)** for the seasonal influenza shot and for the nasal spray. I understand the risks and benefits, and give consent to the Health Department and its authorized staff to vaccinate me with this vaccine.

Signature of Client: X_____ **Date:** _____ **/** _____ **/**_____

SECTION F: OFFICE OF PRIVACY AND SECURITY
Authorization for Disclosure of Protected Health Information

As the person signing this authorization, I understand that I am giving permission to the Virginia Department of Health (VDH) to disclose personal health information to the person(s) or organization(s) indicated below.

- I understand the provision of treatment cannot be conditioned on my signing of this Authorization for Disclosure Section.
- Any health information re-disclosed by you will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included in my medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my health information to my primary care physician.
- I understand that this record will be retained for ten years after the last visit or for five years after age 18, whichever comes later. I authorize VDH release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. The third party payer to pay any authorized benefits to VDH on my behalf.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

SECTION G: NOTICE OF DEEMED CONSENT
(Required by §32.1-45.1 of the Code of Virginia (1950), as amended)

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.

I understand that the Virginia Department of Health will not release private medical records unless authorized above or to continue care.

X_____ _____ _____

Please Print Your Name | Signature | Date

HEALTH DEPARTMENT USE ONLY

Date	Item code	Cost Type	Lot Number	Expiration Date	Vaccine Administration Site	Provider #
	FLU-MIST	Chargeable			NAS	
	QFLU-PFA (Quadrivalent) FLU-MULTI (MD VIAL)	VFC Chargeable 317			RA LA	
Comments:						

Provider Signature: _____ Date: _____/ _____/ _____

Revised 9/19/2014