**2022-2023 Mass Immunization Clinic Encounter Form**

[](https://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=2ahUKEwi62vHC3sTdAhVIU98KHQBxC4QQjRx6BAgBEAU&url=https://www.doorwaysva.org/about-us/in-the-community/arlington-county-logo/&psig=AOvVaw00Lm8j2j38Md7q6rDhLIhO&ust=1537366457606205)

**Arlington County Employee Informed Consent for Influenza Immunization**

***MARK YOUR DEPARTMENT: DHS-non PHD DHS-PH***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| AED | DES | LIB | ADSD | CHSB |
| CAO | DHR | OEM/ECC | BHD | CHPB |
| CBO | DMF | OTHER | CFSD | FASS |
| CCT | DPR | POL | EID | LAB |
| CMO | DTS | RET | DO | MGMT |
| COR | FIRE | SRF |  | OHB |
| CPHD | GDC | TRS | ***Non-County*** | SHB |
| CWA | JDR | VOT | APS |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Birth Date: |  | | Client Name: (Last, First, MI) | |  | | |
| Address: (Street, City, State) | |  | | | | | |
| Phone: |  | Email: | |  | Gender: M F | Date: |  |
| Race | ( )American Ind./AK Native ( ) White  ( )Asian ( ) Declined  ( ) Black/African American ( ) Don’t know  ( )Native HI/Pac Islander ( ) Not Specified | | | | Ethnicity | ( ) Hispanic or Latino  ( ) Non-Hispanic or  ( ) Don’t know  ( ) Declined | |

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

Arlington County Department of Human Services is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any Arlington County Department of Human Services 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 Arlington County Department of Human Services 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 tests.

**RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have read the Notice of Privacy Practices from the Arlington County Department of Human Services

**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. 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.

**Please check the appropriate box.** **Yes No Don’t Know**

|  |  |  |  |
| --- | --- | --- | --- |
| 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 any influenza vaccine? |  |  |  |
| 2. Has the person to be vaccinated ever had Guillain-Barré syndrome? |  |  |  |

*I hereby authorize the doctors, nurses or nurse practitioners of the Arlington County Public Health Division to immunize me or my child named above. I understand the risks and benefits of the immunizations I/my child will receive and have had the opportunity to ask questions. I have received VACCINE INFORMATION STATEMENT(S) or information sheets about the immunizations. I agree that my/ my child's immunization record, date of birth and address may be shared with other health care providers. I understand that this information will be used by health care providers for the care of me/my child and for statistical purposes only. The Deemed Consent for HIV, Hepatitis B or C testing has been explained to me and I understand it. I understand that medical records must be kept for a period of 5 years after my last visit or until age 21, if a minor.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **VACCINES ADMINISTERED- TO BE COMPLETED BY NURSE ADMININSTERING INJECTION** | | | | |
| ** Seasonal Influenza** Influenza Vaccine**: Z23** Immunization Admin Code**: 90686 Funding Source: LHD** | | | | |
| Item Code | **Lot Number** | **Route** | **Administration Site** | Provider # |
| QFLU-PFA (0.5 mL) | Lot: 333N4 Exp: 6/30/23 | IM |  RA  LA |  |

Employee Name Signature     Date

Provider Printed Name Signature Date