County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods, and diverse communities of Fairfax County

ADOLESCENT VACCINATION CONSENT FORM

(Tdap/Td, HPV, Meningococcal ACWY)

Name: _____
Last First Middle

Health Department Use Only

VAMS ID #: _____

Date of Birth: ____/____/____ Age: _____ Gender: ❑ M ❑ F

If minor - parent/guardian's name: _____
Last First M.I.

Address: _____ City: _____ ZIP: _____

Grade: _____ School: _____

IMPORTANT Parent/Guardian Phone # Home: _____ Cell: _____ Work: _____

Emergency Contact: _____ Emergency contact number: _____
(If other than Head of Household)

My child will be 11 years of age or older on the day of the scheduled vaccination clinic: YES ❑ NO ❑

Please check **YES or NO** to all the questions below to determine if your child can receive offered vaccines at school. The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO	UNSURE
Has your child ever had a serious allergic reaction to any medicine, food, vaccine component, yeast, or latex?	❑	❑	❑
Has your child ever had a serious reaction to a previous dose of Tdap/Td, HPV, or meningococcal vaccine in the past?	❑	❑	❑
Did your child experience a coma, decreased level of consciousness, or long or multiple seizures within 7 (seven) days following a dose of DTP, DTaP or Tdap/Td?	❑	❑	❑
Dose your child have a history of seizures or another nervous system problem?	❑	❑	❑
Did you child experience severe localized swelling or rash after a previous dose of DTP, DTaP, Tdap, DT, or TD?	❑	❑	❑
Has your child ever had Guillain-Barré Syndrome (GBS)? **If yes, consult your doctor about receiving Tdap vaccine. (A note may be required to proceed in a school setting.)**	❑	❑	❑
In the past year, has your child received immune (gamma) globulin, blood/blood products, or antiviral drugs?	❑	❑	❑
Does your child have an immune system problem such as cancer, leukemia, HIV/AIDS?	❑	❑	❑
In the past 6 month, has your child taken medications that affect the immune system such as prednisone, or other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's Disease, or psoriasis, or had radiation treatments?	❑	❑	❑
Has your child received vaccinations in the past 4 weeks? If yes, what did they receive? _____	❑	❑	❑
Is your child/teen pregnant? **If yes, your child/teen will not receive the HPV vaccine but can receive the other vaccines**.	❑	❑	❑
Has your child ever felt dizzy or faint before, during, or after a shot?	❑	❑	❑
Is your child anxious about getting shots?	❑	❑	❑

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INSURANCE INFORMATION

Note: Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program.

*** Insurance***: Please answer the following: This information is required for federal funding purposes for VFC vaccines.

My child:
( ) is ***not*** **insured** (not covered by private insurance, Medicaid, Medicaid MCO or FAMIS)
( ) is American Indian or is an Alaska Native
( ) **has Medicaid MCO with (circle your plan)**: Sentara Community Care, Anthem HealthKeepers Plus, Molina Healthcare, United Healthcare Community Plan, or Aetna Better Health
Member ID # as shown on your card: _____ **Is this a FAMIS plan? ❑ Y ❑ N**
( ) has **(circle one) Medicaid** or **FAMIS** that is not a MCO plan: **Medicaid #** _____
( ) has other insurance not listed above.

I authorize Fairfax County Health Department (FCHD) to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third-party payer to pay any authorized benefits to FCHD on my behalf.

_____ _____
Signature of Client, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date signed**

PERMISSION TO SHARE SCHOOL AGED STUDENT'S IMMUNIZATION RECORDS I authorize Fairfax County Health Department (FCHD) to release information my child's immunization record to school systems for the express purpose of meeting school entrance requirements.

_____ _____
Signature of Client, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date signed**

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

FCHD is required by § 32.1 – 45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any FCHD health care professional, worker, or employees 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're the result of the test. Under Va. Code § 32.1 – 45.1, 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 the blood or body fluids of a FCHD 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 (the "AIDS" virus) as well as for Hepatitis B and C. A physician or other health care prover will tell you that person the result of the test.

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CONSENT FOR VACCINATION FOR TDAP/Td, HPV, AND MENINGOCOCCAL ACWY

CONSENT FOR CHILD'S Tdap/Td VACCINATION:

☐ **YES,** I have read the 2021 Vaccination Information Statement (VIS) for the Tdap/Td Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Tdap/Td vaccine (shot**).**

☐ **NO,** I have decided at this time to **decline or defer** the vaccine(s) recommended for my child, as indicated above, by checking this box.

_____ _____

Signature of Client, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date signed**

CONSENT FOR CHILD'S (Meningococcal) MenACWY VACCINATION:

☐ **YES**, I have read the 2021 Vaccination Information Statement (VIS) for the (Meningococcal) MenACWY Vaccine, I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the Meningococcal ACWY vaccine (shot).

Please Note: Your child will receive one dose prior to entering 7th grade and one dose prior to entering 12th grade.

☐ **NO,** I have decided at this time to **decline or defer** the MenACWY vaccine recommended for my child, as indicated above, checking this box.

_____ _____

Signature of Client, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date signed**

CONSENT FOR CHILD'S HPV VACCINATION:

☐ **YES**, I have read the 2021 Vaccination Information Statement (VIS) for the HPV Vaccine. I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the HPV vaccine (shot)**.**

Please Note: **Your child may need 2 or 3 doses depending on age.**

☐ **NO**, I have decided at this time to **decline or defer** the HPV vaccine recommended for my child, as indicated above, by checking this box.

_____ _____

Signature of Parent, Legal Guardian, or Person Acting in Loco Parentis **Date Signed**

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HIPAA Notice of Privacy Practices Summary

Fairfax County understands your privacy is important. Government rules require Fairfax County agencies providing health services to you to protect the privacy of your health care records. Your records include your personal information that can identify you. The health care worker will write in your record information about your health and what treatment you had while they took care of you. If the health care worker wants you to get more services that information will be written in the record too.

Our policy has always been to keep your records safe. We follow the strongest laws that protect your health care information. This poster describes the rights you have from the government rule, the Health Insurance Portability and Accountability Act (HIPAA). We must let you know how we follow this rule. Sometimes federal and state laws will change. If the government rules change, Fairfax County and our agencies, boards, and commissions reserve the right to change our privacy policies and any of our privacy practices at any time. These changes will apply to all of the health care records we keep safe for you.

A Summary of Your Privacy Rights:

- You may ask us to contact you at work or at home. We will try to follow all reasonable requests.
- You have the right to request a copy of your electronic medical record. You can look at your health care record or ask for a copy of the record we keep about you. If we think you may have a bad reaction to some content in the record, we can say no.
- You may access lab reports directly from the laboratory performing the lab test.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say yes unless a law requires us to share this information.
- If you think there is something wrong or missing in your health record, you may ask that it be changed. We do not have to make the change, but we will work with you to include your concerns.
- We may need to show your health record to other people. A law may require us to share your information. We will only share your information when there is a good reason to do so. If you do not want us to share your information with certain people you must let us know. We will try to follow your instructions, but we do not have to do so all the time.
- You may ask for a list of all the people with whom we shared your information. This list will not include times we shared your information with other health care workers about your treatment, for your bill payment, or for our service management. The list will not include those times you said it was OK to share your health information.
- To learn more about your rights and how we may share your information you may request a complete copy of the Notice of Privacy Practices. You may request this notice at any time. One will be given to you when you get health service from us.
- You have the right to be notified in the event that we discover a breach of your unsecured protected health information. • You may write us a letter or e-mail if you think we have violated your privacy rights. Our HIPAA Compliance Officer or the Federal Department of Health and Human Services can help you with your complaint.

For more information about Fairfax County's HIPAA Compliance Program, please contact:

HIPAA Compliance Officer
12000 Government Center Parkway, Suite 527 | Fairfax, VA 22035
Phone: (703) 324-4136 | **TTY:** (703) 968-0217 | **Web:** www.fairfaxcounty.gov/hipaa

Fairfax County is committed to a policy of nondiscrimination in all county programs, services and activities and will provide reasonable accommodations upon request.

❑ **Please check box if you wish to receive a copy of the Fairfax County Health Department Notice of Privacy Practices.**