VISITING NURSE ASSOCIATION OF GREATER ST. LOUIS (VNA)

CONSENT TO TREAT/ ASSIGNMENT/ RELEASE

PATIENT INFORMATION

First Name **MI** **Last Name**

Address Number **Street Name** **Sex M/F**

City **State** **Zip Code**

Age **Date of Birth** **Area Code** **Phone Number**

Race: □ **White** □ **African American/Black** □ **Hawaiian/Pacific Islander** □ **Amer Indian/Alaskan Native** □ **Asian Amer** □ **Two or More Races**

Ethnicity: □ **Hispanic/Latino** □ **Non-Hispanic/Latino**

□ **Copy of Insurance Card** □ **Cash**
(Copy of Card Must Be Attached)
□ **Aetna** □ **Blue Cross Blue Shield** □ **Cigna** □ **Coventry** □ **HealthLink** □ **Humana**

□ **HCUSA (Healthcare USA)** □ **Homestate** □ **Medicaid** □ **Uninsured**

_____ **(Initials)** I have read and been offered to receive a copy of the Notice of Privacy Practices prior to services, and I have had the opportunity to have my questions answered.

VFC Eligibility Status (Select One): □ **Medicaid** □ **No Health Insurance** □ **Amer Indian/Alaskan Native**

Subscriber Name: _____ **Subscriber DOB:** ____/____/____ **Relationship:** _____

Insurance ID Number

VACCINATIONS YOUR CHILD MAY RECEIVE

Tdap (Tetanus-Diphtheria-Pertussis) **Meningococcal**

MEDICAL HISTORY ACKNOWLEDGEMENT

No severe allergic reactions to vaccine components or latex. (NOTE: Multi-dose vials contain Thimerosal.) ●Not moderately ill or have a fever. ● Has written MD approval if pregnant. ● Immune compromised or those who are receiving any immune suppressive therapy may not have the expected immune response. ● For Tdap: No history of seizures or another nervous system problem, sever pain or swelling after any vaccine containing diphtheria, tetanus or pertussis, or Guillain-Barre` Syndrome (GBS)

RELEASE OF INFORMATION

I authorize VNA to release all records and information concerning my vaccination to my employer, to any third party payer, to any other health care provider and to any Federal or State governmental agency, for the purposes of obtaining payment or to facilitate compliance with law.

ASSIGNMENT OF BENEFITS

I acknowledge that VNA may not be a provider for my insurance and may not be submitting a claim for reimbursement. I also acknowledge that, even with a paid receipt, there may not be a guarantee of reimbursement. I AGREE TO PAY THE AMOUNT(S) NOT PAID OR IF MY CHARGES ARE DENIED FOR ANY REASON. I AGREE TO PAY ANY AND ALL COLLECTION COSTS INCLUDING ATTORNEY FEES AND COURT COSTS, IF THIS ACCOUNT IS SENT TO AN OUTSIDE LAW FIRM OR AGENCY FOR COLLECTIONS.

ACKNOWLEDGEMENT

I have read and been offered to receive a copy of the Vaccine Information Statement (*Tdap VIS (rev.2/24/15) and Meningococcal VIS (rev.3/31/16*)) prior to my vaccination(s). I understand all the risks and benefits involved and I have had a chance to ask questions. ● I agree to stay in the general area for 15 minutes after receiving my vaccination to ensure that no immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. Local reactions may include redness, swelling or soreness at the injection site. General reactions may include fever, headache, nausea, vomiting, diarrhea, body aches and rash. Severe reactions may include Guillain-Barre Syndrome, severe shoulder pain. List of reactions is not all inclusive, refer to VIS. ● I hereby release and hold harmless Visiting Nurse Association of Greater St. Louis, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, volunteers and employees, from any and all liabilities or claims whether known or unknown arising out of, or in connection with, or in any way related to the administration of the vaccine(s) listed above.

CONSENT TO RECEIVE VACCINE

I have read this consent and I authorize VNA to give the selected vaccine(s) to me or to the person named above for which I am authorized to sign.

_____/_____/_____**X**_____/_____

Date Signature of Person, Parent or Legal Guardian receiving vaccine / Relationship to Patient

FOR CLINICAL USE ONLY. DO NOT WRITE BELOW THIS LINE.

Clinic ID #

* ***Parents - Fill Out Shaded Portions***

Over

11440 Olive Blvd., Suite 200
St. Louis, MO 63141 **314-918-7171**

FOR CLINICAL USE ONLY

Patients Name: _____ Date of Birth: _____

Medical Questions:
Is patient pregnant? Yes or No *Is child running a fever today?* Yes or No

□ Tdap Route IM Body Site RD LD Dose 1 Lot Given: _____
(GSK-Boostrix)

VNA Nurse Signature _____ Date: _____

School Nurse: _____ to verify that immunizations are needed

□ Meningococcal Route IM Body Site RD LD Dose 1 2 3 Lot Given: _____
(GSK-Menveo)

VNA Nurse Signature _____ Date: _____

School Nurse: _____ to verify that immunizations are needed