VISITING NURSE ASSOCIATION OF GREATER ST. LOUIS (VNA) CONSENT TO TREAT/ ASSIGNMENT/ RELEASE																		
PATIENT INFORMATIO	ON																	
First Name					MI	_	Last I	Name										
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Address Number			Street	Name		_										-	Se	ex M/F
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Age Date of]	Rirth					A	rea Co	de		Ph	one Ni	ımber	Ľ					
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Race: • White • African American/Black • Hawaiian/Pacific Islander • Amer Indian/Alaskan Native • Asian Amer • Two or More Races • Hawaiian/Pacific Islander • Amer Indian/Alaskan Native																		
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(Copy of Card Must Be Att	tached)		~		~										is answ		inty to	nave
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Insurance																		
ID Number																		
VACCINATIONS YOUR	CHILD N	AAY F	RECEI	VE	<u> </u>			VACCINATIONS YOUR CHILD MAY RECEIVE										
VACCINATIONS FOUR CHILD MAT RECEIVE Hepatitis B DTaP (Diphtheria-Pertussis-Tetanus) MMR (Measles-Mumps-Rubella)																		
Hepatitis B	DTaP	(Dipht	theria-I	Pertussis	-Tetan	us)	Μ	IMR (Measle	es-Mı	mps-l	Rubell	a)					
Hepatitis B MMRV (Combined M								IMR (olio	Measle	es-Mı	imps-]	Rubell		arice	lla			
MMRV (Combined M MEDICAL HISTORY A	feasles-Mu	umps-l	Rubella EMENT	a and Va Г	ricella)		Po	olio					١					
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11440 Olive Blvd., Suite 200 St. Louis, MO 63141

FOR CLINICAL USE ONLY

314-918-7171

Patients Name:		Date of Birth:						
Medical Questions: Is patient pregnant?	Yes or No	Is child running	a fever today? Yes or No					
□ Hepatitis B (GSK-Engerix-B)	Route IM Body Site RD LD	Dose 1 2 3	Lot Given:					
VNA Nurse Signature _		Date:						
School Nurse:		to ver	ify that immunizations are needed					
□ DTap (GSK-Infanrix)	Route IM Body Site RD LD	Dose 1 2 3 4	5 Lot Given:					
VNA Nurse Signature _		Date:						
School Nurse:		to ver	ify that immunizations are needed					
 MMRV (Sanofi Pasteur-Proquad) 	Route SQ Body Site RD LD	Dose 1 2	Lot Given:					
VNA Nurse Signature _		Date:						
School Nurse:		to ver	ify that immunizations are needed					
□ Polio (Sanofi-Pasteur-IPOL)	Route IM Body Site RD LD	Dose 1 2 3 4	Lot Given:					
VNA Nurse Signature _		Date:						
School Nurse:		to ver	ify that immunizations are needed					
□ MMR (VFC Only) (Merck-MMRII)	Route SQ Body Site RD LD	Dose 1 2	Lot Given:					
VNA Nurse Signature _		Date:						
School Nurse:		to ver	ify that immunizations are needed					
□Varicella (VFC Only) (Merck-Varivax)	Route SQ Body Site RD LD	Dose 1 2	Lot Given:					
VNA Nurse Signature _		Date:						
School Nurse: _		to ver	ify that immunizations are needed					