

## VISITING NURSE ASSOCIATION OF GREATER ST. LOUIS (VNA) CONSENT TO TREAT/ ASSIGNMENT/ RELEASE

DATIENT INFORMATION															
PATIENT INFORMATION First Name				MI		Last Nai	ne								
					] . [										
					] [										N 7 (T)
Address Number		Street Na	ime						Т					Sex I	VI/F
	•													•	
City									State		Zip C	ode			
								•		•					
Age Date of Birth Area Code Phone Number															
Email (optional)				1	г			1 1			1	1 1			_
			/D1 1		**	/5	· C				T 11	/ . 1	1 37	.•	
Race:   White   African American/Black   Hawaiian/Pacific Islander   American Indian/Alaskan Native															
☐ Asian American ☐ Two or More Races  [Initials] I have read  [Initials] I have read															
Ethnicity:   Hispanic/Latino   Non-Hispanic/Latino   and been offered to receive a copy of the Notice of Privacy															
□ Copy of Insurance Card □ Cash Practices prior to services, and															
(Copy of Card Must Be Attached)  I have had the opportunity to															
my questions and visite															
□ Medicaid (Circle One): Missouri HealthNet/Missouri Care/Homestate/UHC of Midwest □ Uninsured															
VFC Eligibility Status (Select One): □ Medicaid □ No Health Insurance □ Amer Indian/Alaskan Native															
Subscriber Name: Subscriber DOB:/ Relationship:															
Insurance															1
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 Tdon. No history of saigures or enother previous system problem sayer pain or swelling after any vession containing diphtheric															
immune response. ● For <u>Tdap</u> : 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								en							
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															
shoulder pain. List of reactions is not	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								s, its						
														es or cla	aims
whether known or unknown arising ou CONSENT TO RECEIVE VACCIN		in conne	ction w	1th, or 11	n any w	ay relate	d to the	adminis	stration	of the va	iccine(s	listed a	bove.		
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.															
/ / <b>X</b>							/								
	ture of F	Person, Pa	arent or	Legal	Guardia	n receiv	ing vacc	ine / Ro	elationsl	nip to Pa	tient				
FOR CL												E.			
Clinic ID #															
CHIIC ID #															

\*VIS: TDap (Rev. 2/24/15), Meningococcal (Rev. 3/31/16)

Parents - Fill Out Shaded Portions



Over 314-918-7171

## FOR CLINICAL USE ONLY

Patients Name:		Date of Birth:						
Medical Questions:  Is patient pregnant?	Yes or No	Is child ri	unning a fever today? Yes or No					
□ Tdap (GSK-Boostrix)	Route IM Body Site RD LD	Dose 1	Lot Given:					
VNA Nurse Signatu	re		Date:					
School Nurse:			to verify that immunizations are needed					
□ Meningococcal (GSK-Menveo)	Route IM Body Site RD LD	Dose 1 2 3	Lot Given:					
VNA Nurse Signatu	re		Date:					
School Nurse:			to verify that immunizations are needed					