FLU CONSENT TO TREAT – Side 1

(Ages 3 Years to 18 Years)

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

RELEASE OF INFORMATION

I authorize VNA to release all records and information concerning my vaccination to my school, Medicaid or other third party payer for the purposes of obtaining payment or to facilitate compliance with the law.

ASSIGNMENT OF BENEFITS

I authorize VNA to request on my behalf and to collect all public, billed and private insurance payments due for administration of the vaccine (VFC). I authorize VNA to request on my behalf and to collect all public, billed and private insurance payments due for services provided by them. I AGREE TO PAY THE AMOUNT(S) NOT PAID OR IF MY CHARGES ARE DENIED FOR ANY REASON (Providing Insurance Information).

ACKNOWLEDGEMENT

I have read and been offered to receive a copy of the FLU Influenza Vaccine Information Statement (rev.8/7/15) prior to my vaccination. 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. Mild reactions may include redness, swelling or soreness at the injection site. General reactions may include fever, fatigue, or muscle pain 6-12 hours after vaccination that can persist up 1-2 days. Severe reactions may include Guillain-Barrè Syndrome, anaphylaxis or death. ● 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.

COMPLETE ALL INFORMATION BELOW TO RECEIVE FLU VACCINE

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

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

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

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

Email (optional)

Race: □ White □ African American/Black □ Asian Am. □ Hawaiian/Pacific Islander □ American Indian □ Two of More Races

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

_____ **(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.

☐ **Copy of Insurance Card** ☐ **Cash/Check** $ _____

(Copy of Card Must Be Attached)

☐**Aetna** ☐**Anthem/Blue Cross Blue Shield** ☐**Cigna** ☐**Coventry** ☐**HealthLink** ☐**UHC**

☐ **Medicaid** (Missouri Care, MoHealthNet, Homestate)

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

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

Insurance ID Number

TURN OVER AND COMPLETE SIDE 2

FLU Screening Questionnaire – Side 2

Age

First Name ● **Last Name**

FLU SHOT Medical Acknowledgement: 3 years & older	NO	YES
Severe allergic reaction to eggs, egg products, formaldehyde, Thimerosal, vaccine components or latex **Egg free vaccine (Flucelvax) available for children ages 4 years and older*		
Serious reaction to a previous flu vaccine		
Fever today		
History of Guillain-Barrè Syndrome		
Received a flu shot in a previous year		
Allergy to latex		
Pregnant or nursing		

CONSENT TO RECEIVE FLU VACCINE

I have read this consent and I authorize VNA to give FLU vaccine to me or to the person named above for which I am authorized to sign. This consent authorizes both Dose 1 and 2 (if required) for me or 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 CLINIC USE ONLY. DO NOT WRITE BELOW THIS BLACK LINE.

Dose	Flulaval® (3 years & older)	Flucelvax® (4 years & older)
#1	0.5 mL L ● R Deltoid	0.5 mL L ● R Deltoid
#2	0.5 mL L ● R Deltoid	0.5 mL L ● R Deltoid
LOTS Given	#1	#1
	#2	#2

Clinic ID:	Nurse Signature:	Date:

To view the Notice of Privacy Practices for Visiting Nurse Association, visit our website at www.vnastl.org or call us at 314-918-7171 to have a copy sent to you.