



65+ Influenza Virus Vaccine
 VISITING NURSE ASSOCIATION OF GREATER ST. LOUIS (VNA)
 CONSENT TO TREAT/ ASSIGNMENT/ RELEASE

MEDICAL HISTORY ACKNOWLEDGEMENT OF INDIVIDUAL RECEIVING VACCINE

• No severe allergic reactions to eggs, egg products, formaldehyde, vaccine components, or latex. • Does not have an acute respiratory illness or a fever. • No history of Guillain-Barré Syndrome. • Has not had a reaction to a flu vaccine in the past.

ASSIGNMENT OF BENEFITS

I authorize VNA to request on my behalf and to collect all public, billed and private insurance payments due for supplies and vaccine provided by them. **I AGREE TO PAY THE AMOUNT(S) NOT PAID OR IF MY CHARGES ARE DENIED FOR ANY REASON. I AGREE TO PAY ANY/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 current Influenza Vaccine Information Statement (rev.8/6/21) prior to the 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. Reactions may include pain, redness and/or swelling at the injection site, or arm stiffness. General reactions may include muscle pain, malaise, headache or fever that can persist for 1-3 days. Severe reactions may include Guillain-Barré 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 INFLUENZA VACCINATION

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.

First Name										MI	Last Name										
Address Number						Street Name														Gender M/F/Other	
City										State					Zip Code						
Age		Date of Birth				Area Code				Phone Number											
Email (optional)																					

Race: ☐ White ☐ African American/Black ☐ Asian Amer. ☐ Hawaiian/Pacific Islander ☐ Amer. Indian ☐ Two or More Races
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

PLEASE PROVIDE INSURANCE INFORMATION BELOW:

☐ Medicare Part B (only) ☐ Anthem/Blue Cross Blue Shield ☐ Essence ☐ TriCare_____

Medicare Advantage Plan: ☐ Aetna PPO ☐ Cigna PPO ☐ Coventry PPO ☐ Humana PPO
☐ HealthLink PPO ☐ UHC PPO

Subscribers Name: _____ **Subscribers D.O.B.** ____/____/____ **Relationship to subscriber:** _____

(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.

I have read this consent and I authorize VNA to give influenza vaccine to the person named above for which I am authorized to sign.

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

DO NOT WRITE BELOW THIS LINE: Office Use Only

Nurse to indicate payment	INSURANCE MEMBER ID _____		
	☐ Cash ☐ Check # _____ ☐ Bill Client ☐ Voucher ☐ Other _____		
Clinic ID#	X _____ Nurse Signature	____/____/_____ Date Given	0.5 mL Lot Given X Y Z
			IM Site Given Deltoid • Thigh L • R