COVID-19 VACCINE-PFIZER (Age 16 Years & Over)
COVID-19 VACCINE-MODERNA (Age 18 years and Over)

VISITING NURSE ASSOCIATION OF GREATER ST. LOUIS (VNA)

CONSENT TO TREAT/ ASSIGNMENT/ RELEASE

ACKNOWLEDGEMENT

I have read and been offered to receive a copy of the current ***COVID-19 Emergency Use Authorization Fact Sheet*** (12/2020) 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 (if I have severe allergies my wait time may be extended) 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 pain, tenderness and swelling of the lymph nodes in the same arm of the injection, swelling (hardness), and redness. General side effects may include fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting and fever. Severe reactions may include difficulty breathing, swelling of your face and throat, a fast heartbeat, a bad rash all over your body, dizziness and weakness. ● I have been offered a flyer on how to enroll in **V-Safe** ● 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.

ASSIGNMENT OF BENEFITS

I authorize VNA to request on my behalf and to collect all public, billed and private insurance payments due for service provided by them. The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Countermeasures Injury Compensation Program (CICP) to provide benefits to certain individuals or estates of individual who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who dire as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting htts://www.hrsa/gov/cicp/.

COMPLETE ALL INFORMATION BELOW TO RECEIVE COVID VACCINE

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.

First Name ● **MI** ● **Last Name**

Address Number ● **Street Name** ● **Sex M/F/T/O**

City ● **State** ● **Zip Code**

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

Email

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

PLEASE PROVIDE INSURANCE INFORMATION BELOW:

Commercial Insurance Plans:

□Aetna □ Anthem/Blue Cross Blue Shield □ Cigna □ Coventry □ Essence □ Humana □ HealthLink □ UHC

Medicare Plans: □ Medicare Part B □ Anthem/Blue Cross Blue Shield □ Essence

Medicare Advantage Plan: □ Aetna PPO □ Cigna Medicare Access PPO □ Coventry PPO □ HealthLink PPO □ Humana PPO

Missouri Medicaid: □ Homestate Health □ Missouri Care □ UHC MoHealthNet □ Other: _____

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

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HEALTH HISTORY

If answering Yes or Unknown to Questions 2, 3, 7, 8, 9 You Must Contact Your Physician Prior To Your Appointment For Approval To Receive COVID-19 Vaccine

	YES	NO	UNKNOWN
1. Are you moderately or severely ill today? (mild illness or taking antibiotics are not reasons to withhold vaccination) _____ Temperature	□	□	□
2. Do you have any allergies that require you to carry an EPI pen or to latex, foods, medications, or vaccines? If yes, please list _____	□	□	□
3. Have you ever had a serious reaction after a vaccine?	□	□	□
4. In the past 14 days have you:			
Tested Positive for COVID-19?	□	□	□
Had contact with another person with lab confirmed COVID-19?	□	□	□
NOTE: You cannot receive a COVID-19 vaccine during this period.			
5. In the past year, have you been diagnosed with COVID-19 by a medical provider? If yes, date of diagnosis _____/_____/_____	□	□	□
6. Have you received passive antibody therapy for COVID-19 in the past 90 days? NOTE: If yes, you cannot receive a COVID-19 vaccine during this period.	□	□	□
7. Are you breastfeeding, pregnant or planning on becoming pregnant in the next six months?	□	□	□
8. In the past 3 months, have you taken medication that affects your immune system? Such as prednisone, other steroids, anticancer drugs, drugs for treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments?	□	□	□
9. Do you currently have or have you had a history of neurological condition, seizure or have ever had Guillian Barre Syndrome?	□	□	□
10. Have you received any vaccinations in the past 14 days? NOTE: You should not receive a vaccine 14 days prior or after receiving your COVID-19 vaccine.	□	□	□
11. In the past year, have you received a dose of COVID-19 vaccine? If so, when _____ and what brand (circle) Pfizer/ Moderna?	□	□	□

***If I answered yes or unknown to question 2, 3, 7, 8, 9, I confirm that I have spoken to my physician and have approval to receive my COVID-19 vaccination*: Signature: _____**

I have read this consent and I authorize VNA to give COVID-19 vaccine 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

INSURANCE MEMBER ID _____

Clinic ID#	**X** _____ _____/_____/_____ **Nurse Signature** **Date Given**

Manufacturer (Circle One): Moderna Pfizer	Lot Number: _____ Exp. Date: _____/_____/_____	Dose Number: 1 □ 2 □	IM Site Given: Deltoid L ● R