

**St. Vincent HomeCare/VNA Of Arkansas, INC. CONSENT TO TREAT/ ASSIGNMENT/ RELEASE**  
#2 St. Vincent Circle, Little Rock, AR 72205 • Phone 501/664-2313

[illegible]

- No severe allergic reactions to eggs, egg products, chicken protein, vaccine components, or Thimerosal.
- Does not have an acute respiratory illness or a fever.
- No history of Guillain-Barre' Syndrome and does not have an active, uncontrolled neurological disease
- Will not receive a pneumonia shot if currently receiving radiation or chemotherapy, or will be starting in the next two weeks.

- I have read or have been offered a copy of the current Influenza Vaccine Information and/or Pneumococcal Statement prior to my vaccination. I have had a chance to ask questions and I understand all the risks and benefits involved.
- I agree to stay in the general area if this is my **first shot** 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, malaise, or muscle pain 6-12 hours after vaccination that can persist up to 1-2 days.
- *I understand that the Center For Disease Control strongly recommends a flu shot yearly and a pneumonia shot twice in a lifetime, no less than 5 years apart.*

I understand the vaccination is being provided by VISITING NURSE ASSOCIATION OF ARKANSAS. I expressly release from any liability the above named organization and individual giving the vaccine(s). I, for myself, my heirs, executors, and assigns hereby agree to release the site provider and its employees from any and all claims arising out of, in connection with, or in any way related to my receipt of this vaccine(s) in their facilities.

- I authorize VNA to request on my behalf and to collect charges made to Medicare.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Patient Signature (Parent/guardian if patient under 18)  
 Offered/Read/HIPAA Privacy Practices

☐ **MEDICARE:** **sign medicare roster** **DATE:** \_\_\_\_\_

☐ **CASH** \$ \_\_\_\_\_ ☐ **CHECK** # \_\_\_\_\_ \$ \_\_\_\_\_ **CLINIC NAME:** \_\_\_\_\_

**PNE** \_\_\_\_\_ **FLU** \_\_\_\_\_

☐ **COMPANY** ☐ **EMPLOYEE**

**Inactivated Influenza Vaccine** Lot # Given  
0.5cc in \_\_\_\_\_ Deltoid IM

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Nurse Signature \_\_\_\_\_ Allergies \_\_\_\_\_