

Menactra Vaccination Assessment and Consent Form
Meningococcal (Groups A,C,Y and W-135) Polysaccharide Diphtheria Toxoid Conjugate Vaccine
 Provided by Visiting Nurse Association Home Support Services (VNA)

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS NOTIFY THE NURSE BEFORE IMMUNIZATION:

- | | | |
|--------------------------|--------------------------|--|
| Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had the bacterial meningitis shot before? <i>If yes, when?</i> _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a reaction to a bacterial meningitis shot? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a reaction to a Tetanus, Diphtheria, Pertussis (DPT) shot? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you sick with a fever greater than 100 degrees Fahrenheit? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a hypersensitivity to dry natural latex rubber? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you or could you be pregnant or are you a nursing mother? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking any medication(s) (other than birth control)? <i>If yes, specify:</i> _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have an immune deficiency? <i>If yes, specify cause:</i> _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a severe allergic reaction to anything (e.g., hives, breathing difficulties, shock) requiring emergency medical treatment or within 48 hours to a previous vaccine? <i>If yes, please specify</i> _____ |

QUESTIONS

If you have any questions about the bacterial meningitis disease or the Menactra vaccination please ask for clarification from the nurse now or call your doctor before requesting the vaccine. **If you have any questions or concerns following vaccination, please contact the Visiting Nurse Association Home Support Services at 248-967-8751.** If you experience any adverse effects from the Menactra vaccination please contact your physician and notify the Visiting Nurse Association (also notify your employer if you received your vaccination at work).

CONSENT AND RELEASE FOR MENACTRA VACCINE

- I have read the information on the Vaccination Information Statement dated 1-28-2008, regarding the Menactra vaccination. I have received a copy of the Vaccine Information Sheet to keep. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of the Menactra vaccination as described. I request that the vaccine be given to me. I understand the vaccination is being provided by Visiting Nurse Association Home Support Services (VNA). **I expressly release Visiting Nurse Home Support Services, Visiting Nurse Association of Southeast Michigan and any related entities from any liability resulting from the Menactra vaccine itself.**
- I agree to remain under the observation of the nurse administering the injection, for at least 15 minutes. Should I leave before that period lapses, I expressly release Visiting Nurse Home Support Services, Visiting Nurse Association of Southeast Michigan and any related entities from any liability resulting from any adverse reaction to the vaccine or relating to the administration of the vaccine which may occur during the 15 minute period immediately following the vaccination and thereafter.
- I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I understand side effects may include, but are not limited to: pain, swelling, itching, and redness at the injection site, fever and difficulty breathing. Severe reactions may include anaphylaxis and death.
- In the event a VNA employee is exposed to my blood or other bodily fluids, I agree to have my blood tested for HIV and Hepatitis and have the results released to the VNA/exposed person but not to anyone else unless required/authorized by law.
- I acknowledge that I have received written information on the VNA's "Notice of Privacy Practices" prior to the provision of service, and I have had the opportunity to have my questions answered.
- I have been informed that I am responsible to reimburse the VNA for charges not otherwise covered. _____

PATIENT INFORMATION (please print)

_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____	_____
Name (Last, First, Middle)		Birth Date	Age	Weight

_____	_____	_____	_____
Street Address	City/State	Zip Code	Telephone Number

_____	_____	_____
Signature of Recipient/Guardian	Date	Insurance ID #, Group # & Name of Cardholder

Email Address

Procedure Code: 90734	Administration Code: 90471	ICD - 9 Code: V03.89	Tax ID: 38-2566236
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TO BE COMPLETED BY THE NURSE

Dose: .5cc in right left deltoid, IM

Manufacturer/Lot No/Exp. Date _____

_____	_____
Signature of Nurse Administering Injection	Date