Aurora Visiting Nurse Association
of Wisconsin®

Paid: Check # _______
Cash _______

CONSENT TO RECEIVE MENINGOCOCCAL VACCINE

Please PRINT legibly

☐ **F**
Name______________________________ ☐ **M**______________
Last **First** **Date of Birth**

Address____

City ______________________**State**________**Zip** __________**Phone**__________

I have received, read and understand the "Meningococcal Vaccine, What You Need To Know" provided by Visiting Nurse Association (VNA) of Wisconsin. The Meningococcal vaccine covers A/C/Y/W-135 strains. I have had an opportunity to ask questions about the vaccine and my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccination, the alternative modes of treatment, and I expressly consent, request and authorize a nurse to administer the Meningococcal vaccine to me. I agree to stay in the general area for 10-15 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. I hereby release the entity/organization that owns or leases the place in which I receive the vaccination, its officers, employees, and agents, from any and all liability arising from the negligence of VNA, its employees and agents, on behalf of myself, my spouse, my heirs and personal representatives. I hereby release VNA, its officers, employees and agents, from any and all liability arising from this vaccination, except for liability arising from VNA's negligence, on behalf of myself, my spouse, my heirs and personal representatives.

Medical History:

Are you presently moderately or severely ill or have a fever?	No_____Yes________
Are you or do you think you might be pregnant or breast feeding?	No_____Yes________
Have you ever received a Meningococcal vaccination?	No_____Yes________
Have you had a serious reaction to a Meningococcal shot before?	No_____Yes________
Have you had a serious reaction to a diphtheria toxoid (DTP, DTaP or DT shot?)	No_____Yes________
Do you have an allergy or sensitivity to latex?	No_____Yes________

I acknowledge that VNA has provided me a copy of its Notice of Privacy Practices.

X____
Signature of Person to Receive Vaccine ("Person")

X____
Signature of Legal Representative / Relationship to Person

Manufacturer of vaccine sanafi pasteur Lot #____________________ Site: R / L Deltoid

Administered by____ Date_______________