

**Visiting Nurse Association and Hospice**  
**Meningococcal Vaccination Consent Form &**  
**Contraindication Questionnaire**  
**About Person Receiving Vaccine**

CLINIC CODE: \_\_\_\_\_ DATE: \_\_\_\_\_

VACCINATION: **Meningococcal**\_\_\_\_\_

Cash  Check # \_\_\_\_\_

**DO NOT WRITE IN ABOVE SECTION**

- 1. PLEASE PRINT.**
- 2. Fill out all areas NOT shaded.**
- 3. Sign at "X" below.**

Last Name		First Name		MI	Birth Date / /	Age	Phone Number ( )
Address		City	State	County	Zip	Male <input type="checkbox"/> Female <input type="checkbox"/>	

Please check appropriate box:		YES	NO
1	Are you allergic to thimerosal (found in contact lens solution)?		
2	Are you sick with a fever?		
3	Do you have a bleeding disorder (hemophilia or thrombocytopenia, or on anticoagulant therapy)?		
4	Have you ever had a serious reaction to a previous meningococcal vaccination?		
5	Are you pregnant or nursing?		

I have read or have had explained to me information about the meningococcal vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the Meningococcal vaccine, which covers A/ C/ Y/W-135 strains and request that the vaccine be given to me or to the person named above, for whom I am authorized to make this request.

I understand that Visiting Nurse Association is providing the vaccination. I expressly release from any liability the above-named organization and the individual giving the vaccine. 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 receipt of this vaccine in their facilities.

I agree to remain in the area at least 15 minutes and report back to the nurse if any unusual side effects occur before leaving the premises. If any adverse effects from the Meningococcal vaccination occur after I leave, I agree to contact my physician.

***Please make checks payable to VNA.***

**X** \_\_\_\_\_  
 Signature of person receiving vaccine (or person authorized to give permission, if client is under 18) \_\_\_\_\_ Date

**X** \_\_\_\_\_  
 I have received VNA Privacy Practices, VIS 08/16/07

<input type="checkbox"/> All "Yes" responses have been addressed. Given <b>Meningococcal</b> Vaccine Polyvalent 0.5cc in _____ deltoid IM Lot # _____ _____ Nurse's signature _____
--