

ATTENTION 11th Grade PARENTS/GUARDIANS

**Your child can receive the required 12th grade
Meningitis Vaccine right here at school.**

**Timberland's Meningitis Vaccine Clinic
Hosted by the Visiting Nurses Association**

★★★

Tuesday, May 6th, 2025

8am-10am

In the School Nurse's Office

★★★

**TO RESERVE A SPOT,
PLEASE FILL OUT THE ATTACHED CONSENT FORM
AND**

**RETURN TO THE SCHOOL NURSE
BY MONDAY, APRIL 28TH, 2025.**

**VIRTUAL and IN-PERSON SUMMER SCHOOL STUDENTS
must have the required vaccine on file
PRIOR TO STARTING SUMMER SCHOOL.**

PATIENT INFORMATION

First Name										MI	Last Name													
Address Number						Street Name																		Sex
City														State		Zip Code								
Age		Date of Birth				Area Code			Phone Number															
Email (optional)																								

Race: ☐ White ☐ African American/Black ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Asian American ☐ Two or More Race

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

☐ **Copy of Insurance Card** *(Copy of Card Must Be Attached)* ☐ **Cash**
☐ **Aetna** ☐ **Anthem/Blue Cross Blue Shield** ☐ **Cigna** ☐ **Humana** ☐ **HealthLink**
☐ **UHC** ☐ **UMR** ☐ **AllSavers** ☐ **GEHA** ☐ **GoldenRule** ☐ **TriCare** ☐ **Medica**

VFC Eligibility Status (Select One): ☐ Medicaid ☐ No Health Insurance ☐ Amer Indian/Alaskan Native

☐ **Medicaid (Circle One):** Missouri HealthNet/Missouri Care/Homestate/UHC (list plan)

Subscriber Name: _____ **Subscriber DOB:** ____ / ____ / ____ **Relationship:** _____

[illegible]

 (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.

VACCINATIONS YOUR CHILD MAY RECEIVE

Tdap (Tetanus-Diphtheria-Pertussis)

Meningococcal

MEDICAL HISTORY ACKNOWLEDGEMENT

No severe allergic reactions to vaccine components or latex. (NOTE: Multi-dose vials contain Thimerosal.) • Not moderately ill or have a fever. • Has written MD approval if pregnant. • Immune compromised or those who are receiving any immune suppressive therapy may not have the expected immune response. • For Tdap: No history of seizures or another nervous system problem, sever pain or swelling after any vaccine containing diphtheria, tetanus or pertussis, or Guillain-Barre' Syndrome (GBS)

RELEASE OF INFORMATION

I authorize VNA to release all records and information concerning my vaccination to my school, to any third party payer, to any other health care provider and to any Federal or State governmental agency, for the purposes of requiring proof, obtaining payment or to facilitate compliance with law.

ASSIGNMENT OF BENEFITS

I acknowledge that VNA may not be a provider for my insurance and may not be submitting a claim for reimbursement. I also acknowledge that, even with a paid receipt, there may not be a guarantee of reimbursement. I AGREE TO PAY THE AMOUNT(S) NOT PAID OR IF MY CHARGES ARE DENIED FOR ANY REASON. I AGREE TO PAY ANY AND ALL COLLECTION COSTS INCLUDING ATTORNEY FEES AND COURT COSTS, IF THIS ACCOUNT IS SENT TO AN OUTSIDE LAW FIRM OR AGENCY FOR COLLECTIONS.

ACKNOWLEDGEMENT

I have read and been offered to receive a copy of the Vaccine Information Statement (**VIS*) prior to my vaccination(s). 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 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. Local reactions may include redness, swelling or soreness at the injection site. General reactions may include fever, headache, nausea, vomiting, diarrhea, body aches and rash. Severe reactions may include Guillain-Barre Syndrome, severe shoulder pain. List of reactions is not all inclusive, refer to VIS. • 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.

CONSENT TO RECEIVE VACCINE

I have read this consent and I authorize VNA to give the selected vaccine(s) to me or to the person named above for which I am authorized to sign.

Date _____ / _____ / _____ X _____ / _____
Signature of Person, Parent or Legal Guardian receiving vaccine / Relationship to Patient

FOR CLINICAL USE ONLY. DO NOT WRITE BELOW THIS LINE.

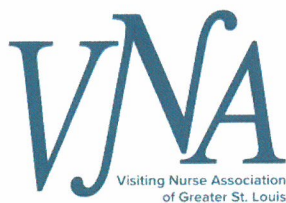
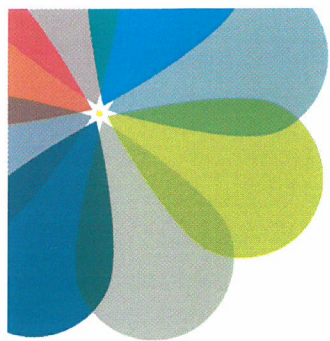
Clinic ID #









*VIS QR Code:
Tdap & Meningococcal

Parents - Fill Out Shaded Portions

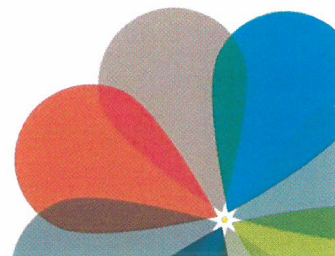
Over

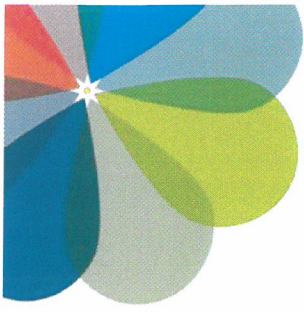


Accepted Commercial Insurances – 2025

-  **Aetna (No EPS's)**
-  **Anthem-Blue Cross and Blue Shield (No EPO's)**
-  **Cigna (No EPO's)**
-  **Coventry**
-  **HealthLink**
-  **Humana**
-  **Medica**
-  **TRICARE**
-  **United HealthCare**

○ (including AllSavers, GoldenRule, UMR, & GEHA)





Medicare Plans:

- Medicare Part B
- Aetna (HMO/PPO)
- Anthem/BCBS Advantage (HMO/PPO)
- Essence



Medicare Advantage Plans – PPO Only (no HMO):

- Cigna
- Coventry
- Humana
- UHC (including PPO AARP)



Missouri Medicaid (18 and Younger Only)

- Homestate Health
- Missouri Care
- United HealthCare Community Plans
- Healthy Blue
- Ambetter
- MO Healthnet

******VNA cannot accept Medicaid plans for those over the age of 18.**

