

Immunization Record

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Information** | | | | | | | | | |
| Last Name | First Name | | | | | M.I. | Date of Birth  | | | | Age |
| Address | | | | | | **M**   **F** **Other** | | | |
| City | | | State | | | Zip | | Phone: | |
| Do you have insurance? If yes name of company: | | Insurance ID#: | | | | | | Payment $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cash Check Credit Card | |
| Do you have a financial hardship?  Yes No | | Are you disabled?  Yes No | | | | | |  | |
| **Race:** American Indian/ Asian Native Hawaiian/ Black/ White Other  Alaskan Native Pacific Islander African American | | | | | | | | | |
| **Ethnicity:** Hispanic or Latino Not Hispanic or Latino | | | | | | | | | |
| **Primary Language Spoken: Vaccine(s) Requested: Flu COVID Other** | | | | | | | | | |
| **Risk Assessment** – Please review and **circle** as appropriate. **If YES, *explain briefly.*** | | | | | | | | | |
| * Have you had a serious reaction to any immunizations in the past? (Please specify) | | | | No | Yes | | | | |
| * Do you have a history of Guillain-Barre Syndrome? | | | | No | Yes | | | | |
| * Have you been sick with a fever in the last 3 days? | | | | No | Yes | | | | |
| * Are you pregnant, or think you might be? | | | | No | Yes | | | | |
| * Are you allergic to Thimerosal? | | | | No | Yes | | | | |
| * Are you immunocompromised? | | | | No | Yes | | | | |

**Consent**

* I agree to remain fifteen (15) minutes following immunization, and I certify the information is correct.
* I give permission for Northern Light Home Care & Hospice to administer the vaccine(s).
* I have read or had explained to me the current Vaccine Information Statement.
* I have had the opportunity to ask questions and understand the benefits and risks of vaccination.
* I authorize the release of any medical or other information necessary to process a claim for insurance payment.
* I understand that I may be responsible for charges not covered by my insurance provider.
* I have received or have been offered a copy of the agency’s Notice of Privacy Practices.
* I request that the vaccine(s) be given to me or to the person named above, for whom I am the legal guardian.
* I understand that I am liable for the vaccine and administration costs. My insurance company may cover all or a portion of this cost depending on which plan I have.

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**Signature** of client or person authorized to make request (parent or guardian)

**Administration**

In Home Use: Client SP or HOS#

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Vaccine Type | Manufacturer | Lot # | Dose Volume | Body Site | Route | VIS Date | Signature and Title of Vaccinator |
|  | Flu |  |  |  |  |  |  |  |
|  | COVID |  |  |  |  |  |  |  |
|  | Other |  |  |  |  |  |  |  |

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